Towards the re-construction of a clinical psychologist and a reflexive body of practice

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TOWARDS THE RE-CONSTRUCTION OF A CLINICAL PSYCHOLOGIST AND A REFLEXIVE BODY OF PRACTICE.

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TOWARD THE RE-CONSTRUCTION OF A CLINICAL PSYCHOLOGIST AND A REFLEXIVE BODY OF PRACTICE.

SUMMARY.

In this thesis qualitative research methods are used to inquire into the author's practice as a Clinical Psychologist in a mental health setting. Questions are posed about the roles the author plays in relation to multi-disciplinary teams and the wider organisation, and about how these intersect with and inform clinical practice with clients presenting to the author's service.

Action research methods and related theory are considered as to their suitability for inquiring into these questions and are tried out in practice. Cooperative Inquiry (Heron 1981, Reason 1988) and Action Inquiry (Torbert, 1981a, 1991) are the two particular action research methods chosen and explored. Data is collected through participant observation and field texts are created in the form of field notes, diaries, reflective diaries and written accounts in 'storied' form.

Interpretive inquiry strategies based in constructivist theory are used to complement the action research methods and in particular, Narrative Inquiry is used as a framework for analysing field texts and for constructing the final thesis.

The research process is an emergent one in that it starts from the author's experience in the work setting, seeks to find theoretical and methodological frameworks which potentially offer answers to the research questions, then tests them out in practice. Outcomes from practice are used to refine the research questions and the methodology, which are then further tested out in practice. Cycles of action and reflection characterise this research process.

Over the course of the research, themes of gender and power emerge as being central to the personal learning of the author and to the simultaneous issues of organisational change and clinical practice with which the author engages.

The findings from the research are considered in relation to the author's conception of himself as a clinical psychologist and the implications for professional practice.

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THESIS OVERVIEW.

This thesis, or research account, is about an inquiry into my own professional practice as well as an inquiry into the setting in which I work and how I and others have participated in change. It represents some significant personal developments and in the telling of it I would like to honour the sense of 'journey' which I experienced. The thesis is written in three sections, each with its own introduction signalling what is contained therein. I will briefly summarise each section here in order to give the reader at the outset a sense of the overall 'shape' of the research as well as a sense of how it developed over time.

Section One.

This section is about 'preparations' for the research journey in which I present myself, the research setting and the research questions I began with. I tell some 'stories' about past experiences which illustrate and contain the research questions and place them in an historical and social context. I also describe theories and methodologies which appear to 'fit' with my research questions, and I begin to engage with issues of validity or quality or knowing. I decide that Cooperative Inquiry best fits my research questions and my values and intentions as a researcher.

Section Two.

This section describes how I explore the possibilities for a Cooperative Inquiry, seeking to invite colleagues to join me as co-researchers/co-subjects . I decide on working with 'complex cases' as a focus around which we can all inquire together into our own practice, this term referring to the 'acting system' of family, social and professional networks involved with an individual person presenting as the identified client. However, I fail to initiate a Cooperative Inquiry as I understood it and I feel unable to begin a research venture which involves colleagues as explicit co-researchers within the frameworks I had chosen. But, I continue to inquire into my own practice using concepts from Action Inquiry and I also develop my own set of criteria for story writing as a method for recording and analysing experience. I am unable to resolve the 'research versus practice' distinction, see myself as not having 'begun the research', and this tilts me into a crisis. I am offered a resolution of this by a feminist critique of social science and a gender analysis.

Section Three.

By now I am able to resolve the 'research versus practice' distinction and continue inquiring into how I and others work with 'complex cases'. I retain this as a focus for a while to hold my questions about how to develop collaborative relationships among all participants and how to contribute towards a 'community of inquiry'. In pursuing these questions I move away from the focus on casework, to a focus on relationships in the work setting around coping with and managing change. This leads to my re-conceptualising how I understand and work with the theme of power. I finish by presenting my own conception of reflexivity in practice and consider how this relates to my practice as a clinical psychologist.

SECTION ONE OVERVIEW.

As I have mentioned in the Thesis Overview, this research account tells of a journey. As all journeys start somewhere and require preparations, I would like to describe this process in this section.

In Chapter One I will present myself and the research setting and be as explicit as possible about the values, intentions, questions and frameworks I held at the outset and as I began the first steps. To some extent, enrolling for a PhD is a somewhat arbitrary punctuation of 'journey beginning', but it is a useful one because it forms a rite of transition where the researcher announces her or his intentions, begins drawing ideas into focus and engages in the journey in more systematic, rigorous and explicit ways. This was the case for me.

In this chapter I will also sketch the setting I work in and the people who inhabit it, create it and give it life. This is also the setting for the inquiry and as such the relationships between individuals and groups within this setting provide a major context for understanding personal experience. I would like to give my picture of this at the outset of the research. My awareness of self and of the organisation both informed the inquiry process and in turn was changed by it over time as the inquiry progressed.

In Chapter Two I introduce Narrative Inquiry as a methodology and make a case for using it to aid in the creation of this thesis as a narrative. Over the course of this research I came to use story-telling as a means of representing experience in the research field as well as a means of inquiry into my own personal process as a researcher. This started inadvertantly and intuitively and it was only towards the end of the research that I more fully considered Narrative Inquiry as more systematic means of inquiring into personal experience. However, I take licence to use Narrative Inquiry early in this thesis as a means of aiding its production.

In chapter three I will tell several 'stories' about past experiences which illustrate in more metaphorical form some of the key issues I seek to address in this research. They can also be seen as preparations for the journey and provide a context for understanding some of my motivations and questions informing the research. Working awarely with one's own personal process as a researcher is a validity issue in the emerging new paradigm approaches to research, one which I will return to at various points. This section is intended to chart the beginnings of this awareness and to locate the reader in the field of research.

Finally, in Chapter Four I will introduce the key theoretical and methodological frameworks which underpin the beginning of the inquiry process. This will provide a theoretical grounding which I will refer to , dialogue with and elaborate upon as the inquiry unfolds.

1. PRESENTING MYSELF, THE RESEARCH SETTING, AND EARLY RESEARCH QUESTIONS.

Presenting myself.

I enrolled at Bath University in the PhD programme several months after starting a new job as a Clinical Psychologist in an NHS Mental Health Unit. By that time I had been in the country for just on two years after moving here from New Zealand. For my wife Jan it was a return home after thirty years away, whereas for me and the children it was a first encounter. At both a professional and personal level I had experienced these two years as a time of adapting to a new culture. Although very similar to the one I had come from, there were many subtle differences and much family discussion in those first two years was about comparing and contrasting as we explored and made sense of our new surroundings. We were still 'feeling our way'.

Professionally I had come with strong roles as a practitioner and as a teacher and trainer and found that these were well received. However, my researcher role had been underdeveloped over the years, relegated to the background, remaining muted. Coming to a new country offered the opportunity to develop this role and I found a greater receptivity and encouragement for research here than I had experienced in New Zealand. In a different social and political climate I felt more liberated to explore the possibilities for research. But first, some background to why this was so and how this influenced my approach to research.

Research as 'problematic'.

By the time I enrolled at Bath I had been working as a Clinical Psychologist for twelve years. Two of these had been spent in Australia immediately after qualifying, followed by eight in Auckland, the largest city in New Zealand and the largest Polynesian city in the Pacific. I had worked across a variety of settings with a broad range of client groups. Over that period I had moved away from the mainstream models which informed Clinical Psychology in the western world.

Clinical Psychology formally presents itself as occupying a unique position among healthcare professionals through its adherence to the Scientist Practitioner model, in which practice is said to be informed by research based theories and methods. The latter are rooted in the experimental and applied experimental tradition, carried out in either laboratories or highly controlled settings, with a view to confirming or disconfirming a priori hypotheses about the events in question.

In practice, the prevailing model for treating or intervening in psychological disorder or distress is Cognitive and Behavioural Therapy. Essentially, this posited that the individual had learned 'maladaptive' ways of both appraising and responding to a presumed objective reality. It was the task of the therapist to help him or her to unlearn these maladaptive responses and re-learn new and 'more adaptive' responses. The Scientist Practitioner model eschews the more

traditional forms of psycho-dynamic psychotherapy (originating with Freud) on the grounds that (within its own frame of reference) they were not based on theoretical models that could be demonstrated through research to be effective.

While this model and its methods has its place with a certain range of problems, to my mind they did not address the complexity I encountered in working with families, groups and organisations in trying to develop increasingly effective mental health services which worked with people in the context of their daily lives. Instead, I was drawn to family systems models such as Minuchin's (1974) Structural Family Therapy, the so-called 'strategic' therapies of Hayley (1976) and Watzlawick, Weakland and Fisch (1974), and the 'Milan systemic' model of Palazzoli et al (1978). These were grouped together under the family systems umbrella and acknowledged a debt to the thinking of key individuals such as Bateson (1972, 1979). These approaches were characterised by a view that mental health problems were best understood and worked with by seeing the person in the context of family and social relationships. It was assumed that problems were embedded in patterns of relationship and these patterns required change for problems to be resolved. The practice of these forms of therapy required the therapist to shift towards seeing meanings or realities as being shaped by and shaping in turn these significant relationships. Therefore, there were different 'realities' or aspects of reality according to the unique sense each individual and family made of their lives.

I found this approach met with my own interests and provided me with ways of practising which allowed me to feel more therapeutic and effective in working with clients and the dilemmas they faced in their lives. It also lent some ideas to the day to day challenge of delivering mental health services which were relevant and accessible to clients.

Over the years I had come to respect social and cultural as well as individual dimensions to mental health. This had led me to working in voluntary and statutory organisations and with different cultural groups, looking for opportunities to expand my knowledge and expertise and at the same time develop services which met need in a more flexible way. I had also developed the idea that there was a social change dimension to addressing mental health problems, as increasingly the connections with poor housing, social isolation and unemployment became clearer over the course of the 1970's and 80's in New Zealand. I also saw that social change was needed within services as they were required to adapt in order to meet the needs of their target groups. This was particularly so in the move away from mental health services being provided solely in hospitals towards being increasingly provided in the communities in which people lived.

I had increasingly found myself paying a good deal of attention to the interface between clients and the agencies I worked for. How we as health workers interacted with each other seemed inextricably related to how we interacted with our clients and the local communities so that change could be facilitated. I became increasingly interested in the possibilities for partnership as I learned through experience how volunteer workers and both formal and

informal networks in local communities could contribute powerfully to helping individuals and families in crisis. This meant in practice that I paid attention to how I related to colleagues and how we as a group related to clients. I found it difficult to turn a 'blind eye' to team problems or incongruities between espoused values and practice, and would work hard to resolve these. I was not aware of the degree to which this was apparent to colleagues I had worked with until I came to leave New Zealand. All of the written references I received commented on this as a role valued by others.

This growing interest lead me to changing jobs about every two years, moving to take what I saw as opportunities for developing new services, or changing existing ones, so that the needs of people with mental health problems in the larger community in which I lived could be met in more relevant and accessible ways. I took on roles as family therapist, trainer, consultant, service manager and project leader, in addition to also providing some of the more traditional roles expected of a clinical psychologist. In doing this I departed from the usual roles my psychologist colleagues played and together with the shift in theoretical orientation I found myself in an ambivalent relationship with psychology. On the one hand I came from psychology and gained privilege from this in terms of gaining jobs and a certain status. I also had to acknowledge that I had learned a set of skills that prepared me to be an effective problem solver within certain domains.

On the other hand, I felt uncomfortable at its narrow focus and its overall unwillingness as I saw it to embrace the social world. While I maintained professional relationships with psychology colleagues and was professionally active in contributing in small ways to teaching and training of Clinical Psychologist trainees, I felt I had to look outside the profession for colleagues who thought similarly

Allied to this shift in practice focus was a shift in how I saw research. In moving away from the more traditional and individually focused models for practice, I had also moved myself away from the more traditional models for research and evaluation. The experimental or applied experimental models for research were still held as the ideal, but they had never left me feeling particularly comfortable. The methods neither seemed to be able to answer the questions I wanted to ask, nor did they seem to offer a way of relating to 'subjects' which valued their contributions or contributed directly to their particular need. My only formal endeavour in research was for a dissertation for my Master's degree. This was an applied experimental approach with a control group which investigated 'cognitive deficits' in young people diagnosed Schizophrenic. I can still recall the discomfort and sense of shame I felt at my inability to adequately or convincingly answer the questions they asked about the experimental tasks, and about the 'why' of the research and what the findings would mean for them. The research helped me qualify but I doubt it helped the 'subjects' in any way.

If I was to engage in research it would have to be congruent with my changing world view. I had moved to assuming that people's thoughts and actions could be made sense of in a

variety of ways by taking into account their individual histories and their family, social and cultural contexts. I believed that if I could understand or gain access to the contexts in which mental health problems were located, then I could find ways of working which by-passed guilt or blame, affirmed competence, and promoted an understanding that each person was doing their best within the limits of their experience, their social setting and the resources available to them. Researching from this perspective with the models I was aware of seemed impossibly difficult. This was not always consciously held but occupied a position at the edge of my awareness and took centre ground whenever I thought of myself doing research. I seemed to be in the midst of a tangle of questions about my practice which merely led to more questions, and I felt easily overwhelmed and defeated when contemplating research. In addition, I had learned to work across a variety of theoretical and practice frameworks and I could not account to myself at any one time which had been the determining factors in either success or failures. Such an approach did not fit with the research approaches I was aware of. I had a small network of colleagues who worked in the same broad territory, but none of us were researchers. I did not have access to a research community which could help with these dilemmas and so my doubts and vulnerability about doing research remained private.

Further restraints on 'researcher self'.

It is important to note at this point that research was low on my agenda during these years for other reasons, both personal and social. As I felt strongly about service delivery I tended to see research as a luxury in the midst of scarce resources. I felt strongly about research projects started by others which seemed to become the 'tail which wagged the dog' and cut across what I saw as good practice. For example, in job earlier in my career in New Zealand, a consultant psychiatrist colleague insisted on admitting to hospital all women who presented for help to the service with depression. He had recently arrived to work in a ward on which I worked half-time. The other half of my time was spent in the community mental health centre which served the same catchment area and which was set up to prevent, as far as was possible and appropriate, admissions to hospital. The staff in this centre saw social factors as playing a strong role in mental health problems and prided themselves in setting up crisis services and local support networks which had halved the number of women admitted to psychiatric hospitals with depression over the preceding three years. The consultant, by contrast, believed that depression was biologically determined and had set up a research trial to investigate it which required women to be admitted to hospital in order to be available to take part. It took a considerable time to develop a viable working relationship with him in which research decisions did not dictate how clients needs were best met.

At a wider social level, I found it difficult to engage in research because of a powerful cross-cultural dialogue which had emerged in New Zealand society. The indigenous Maori people had developed an increasingly powerful voice which said that the most important item on the health agenda in New Zealand was the survival of them as a race. Although they comprised only ten percent of the population they were hugely over-represented in prisons, in social

services care homes, in first admissions to psychiatric hospitals, in road accidents, in illness and mortality statistics. They were a dying race, on the verge of losing their language, their health, their spirituality and extended family and tribal structures. These were all connected fundamentally to the land, which they had substantially lost in the last century. They argued convincingly (to me) that health care would only work for them if provided in culturally relevant and acceptable ways by people who were competent in that culture. Their argument was that they should be given their share of resources and the necessary decision-making power to develop their own services in the context of their own beliefs. Any involvement of Pakeha (European) health professionals would only be acceptable on a partnership basis.

I felt this to be an enormous challenge which I could not in good faith avoid, and so, with a small group of other Pakeha colleagues, became very fully involved in working with Maori people in developing services which were meaningful to them. I will illustrate some of the issues this raised for me in terms of becoming a researcher later. But for the moment, I wish to make the point that these events provided for me a further constraint on doing research as I understood it to be. Providing relevant services in the face of such urgency and competition for scarce resources pushed research to the bottom of my personal agenda.

Indeed, in that setting research would have been seen as counter to the spirit of the partnership. As the more radical Maori groups developed an increasingly sophisticated political analysis of their situation, they were clear it was their job to work with their own people, whereas it was the Pakeha's job to work with their own and raise consciousness about institutional racism. Their purpose was to regain sovereignty over their own culture, and regaining health was inextricably related to this. Against this background, and given my values and understandings about what constituted research, I effectively ruled myself out from being a researcher.

Beginning to see myself as a potential researcher

On arriving in England, my views about research changed. Firstly, I felt freer in a new cultural context to be more curious about my role as a researcher. Here I was a member of the 'host' culture, no longer a member of a visiting dominant culture which was hosted by the 'people of the land' who were physically and metaphorically at risk of dying.

Secondly, in my first job in England I worked with colleagues who had a more embracing notion of research as being part of professional practice, albeit still predominantly within the prevailing traditional scientific paradigm. My first boss persistently challenged me to begin a small research project on some aspect of my practice in order to 'break the ice'. I felt able for the first time in my life to confront research on my own terms. I also wondered if I could feel more a part of the Psychology community.

At that time, Clinical Psychology in Britain was going through an exercise of reviewing itself in relation to new directions in the NHS, looking at 'manpower' issues such as supply and demand, and future trends for the profession. Critical commentators on this exercise (e.g.

Pilgrim and Treacher, 1992) saw this as an unashamed marketing exercise in the face of likely competition from other professionals and non-professional workers in the new 'Health care as an internal market-place' orientation being promoted by central government. However this review was seen, it proposed a model for practice which was widely adopted. The model comprised three levels of expertise. Level one described a level of psychological competence required by all who worked face to face with clients/patients. Level two described a level of skill and knowledge acquired by other health professionals under the tutelage of Clinical Psychologists in order to deliver circumscribed treatments and interventions for targeted problems. Level three was a level of expertise owned only by fully trained and experienced Clinical Psychologists who had a broad range of theory and methodology to draw upon to design interventions at the level of individual clients/patients, teams and organisations. This level was called a 'Consultancy' level and the review advocated that Psychologists needed to develop this more fully in order to 'survive' cuts in services and increasing restrictions on 'manpower' in health.

Whilst I was sceptical that Clinical Psychologists would be capable of this on the basis of their original training and the Scientist Practitioner model, I could see merits in some psychologist developing this Level Three competency. Against this background I saw myself as needing to develop my researcher role in order to become more fully rounded professionally.

Finding a starting point

In thinking about where to start, I kept returning to a prevailing question which had trailed along with me through my work. I had often had the experience of doing work which was effective in producing change of some sort, but which left me thinking along the following lines.

> That was successful, but I am not exactly sure why. My view of it will most likely be different from each person involved. It has something to do with entering how others see the world and with providing different ways of seeing things. But I do not feel as if I have the tools to evaluated this as each case/situation is different. I am curious about what it is that I do because I believe that my involvement is part of things shifting in different direction. Yet, I cannot claim credit for this any more than the others involved. I am also wary about being too public about what I do as I feel I may, in some unaccountable way, give away 'power'.

So, I came into the research looking for an approach which fitted my beliefs and values and which helped me to understand in a more rigorous way what it was that "I" did when I worked. I came not only with an interest in the personal, but also the social. Alongside this I carried some questions about making public what I did and some questions about my relationship with Clinical Psychology and with the teams and agencies with whom I worked. I will return to these questions in more detail after describing my work/research setting.

The research setting.

At this point I would like to provide an initial description of my work setting and my motivations on joining it by way of sketching a backdrop for later developments in my research enterprise.

My hopes and fears.

The parent organisation I joined at the outset of beginning the research was an NHS Mental Health Unit which provided comprehensive services to people with mental health and mental illness problems. Within this unit I belonged to a small department of about forty staff members specialising in addictive behaviour. At that stage, I was the sole psychologist with responsibility for specialist psychological services within the department. We served not only the local health district but also the surrounding health region. Our department was the smallest of five within the unit and at that stage we were all being prepared to become a Trust within the NHS reforms, with the change in management arrangements that entailed.

The other four departments, which at a later stage I was to have some involvement with, were organised around provision of mental health services to children and adolescents, the elderly, and adults.

I had several motives in taking up this job. I needed to work closer to home and regain lost time from daily commuting as I had spent the previous two years working in a neighbouring county. I needed to both live and work in the same locality to establish a stronger sense of interconnectedness within my new chosen country. But professionally, I needed to be a part of a work organisation which was more alive to itself and to the possibility of continuous change and development. This position had been newly created along with several others in recognition of the need for change and development and I was attracted to the idea of being in on the ground floor.

My previous work pattern had been one of continuous movement, staying for no more than two years in a position in order to develop some new aspect of the service before moving on. This had meant a lot of rapid learning for me and now I wanted a different experience, of being in a service over a longer period, to be a part of a longer term development. I was curious about what skills that would take and how I would handle this. I was also wanting a base for consolidating many of the things I had learned, and I wanted to feel I 'belonged' in my chosen community. The choice of this job therefore was a mixture of pragmatism and hope.

It was also a risk and a gamble because from previous contacts with the parent organisation I had developed impressions of it as being a static one which had been slow to undertake moves towards community based services. It had a very close connection with a medical school in training psychiatrists and doing research and I recalled my earlier experiences in New Zealand and the tensions between doing research and giving a service. I was also aware that I was returning to a psychiatric hospital setting and I had some ambivalence about that. In my frequent job changes in the past there had been a pattern of seeking to escape from the

confines of institutions but then being drawn back to them by the challenge of opening them up to the wider world - to make them more a part of a planned continuum of care, open and relevant, as opposed to being closed and a repository for people for whom 'social control' was the covert agenda.

A brief history of the service.

At this stage, I need to dwell briefly on the history of the department before my arrival, as this explained for me some of the issues which arose during the initial period of change. Historically there had been two separate services, one for drug problems which was community-based and non residential, and one for alcohol which was residential and hospital-based. Some of the staff had worked in both at various times but each service ran along different lines, offered different components of treatment and care and operated from different sites. The client groups which each served shared similar problems, in terms of addictions and substance misuse, but were distinguished by the legal/illegal nature of the substances they used and the different sub-cultures which develop accordingly.

The first major change in this arrangement had occurred two years earlier upon the arrival of William, the new Clinical Director. He had rapidly dismantled the existing alcohol service and had developed one which was more responsive to the needs of referrers and clients for shorter waiting lists and a broader range of interventions. Before that the service had revolved almost entirely around a six week residential group therapy programme which had been run mainly by the nursing staff. For several years they had enjoyed high levels of autonomy in the absence of a senior medical person in the role of clinical director.

'Key Players'

This was a term I heard used by staff in my early months in the job. I read it as denoting who was seen as having potential influence in shaping the direction of the service with the impending developments. Gerry was the senior clinical nurse who had been appointed six months before my arrival. This was his first senior post and he came highly recommended by his previous employers and was keen to be seen as playing an influential role. This was a major move for him as he had relocated his family to take the job. After meeting him as part of my orientation, where we swapped backgrounds and professional interests, he remarked "I can see you are going to be a key player". I took that as a compliment but also felt it to indicate that I had been 'sized up' as to the degree of influence I was likely to have and the implications for the relationship we might have with each other. It contained a competitive edge for me that I was to feel with several other senior male colleagues who had recently joined. On the other hand I was also to experience strong bids for alliance from some of the more junior staff who had been there for some time.

Shortly after my arrival, we were joined by Stewart who was to be the second consultant psychiatrist, specialising in drug problems. This was his first job as a consultant psychiatrist (although he had experience in a general medical field previously) and he was keen to develop

the drugs service which William had left untouched. Like William, Stewart had come to this job directly from a teaching position in the university. Both had an espoused interest in mainstream cognitive and behavioural treatments for problems associated with addictions, and both had researched and published in this area. Stewart particularly made clear his views that this was the 'way to go' in providing psychological services. Both had very strong opinions about how services should be organised and delivered, but neither had much experience of putting this into practice. It was evident that they were unclear about how they were going to delineate their areas of responsibility, apart from dividing their work along their separate interests in alcohol and drugs respectively. As consultants they would automatically generate referrals which then required the resources of other disciplines. They had not considered how they would negotiate this and what the implications would be for others' workloads.

We were then joined by my wife Jan who filled a new and combined post of Service manager and Assistant Director Of Nursing Services. She and I had enjoyed working together at different times in New Zealand and were looking forward to doing so again, especially as we had also enrolled together at Bath in the postgraduate group. Her responsibilities were for professional and managerial leadership to nurses within several departments, and for the management and administration of the business aspects of our department. She and I had worked together jointly with clients as family therapists in the past, before she moved on to management and organisational change roles. We shared a similar language as professionals as well as having a personal partnership. From my experience of working with her I knew that one of her strengths was her ability to work with different professional groups in the interests of developing innovative services while still advocating strongly for nursing as a profession. In the past we had managed to use our personal partnership as a strength in our professional partnership and I had no doubts that it would be the case again. However, I wondered how we would be seen by colleagues - would they see us as a couple at the expense of our individual selves, would differences with one become differences with both, and if so would this compromise open relationships in the department?.

With the arrival of all the new senior staff we were able to begin the task of integrating into a combined and comprehensive clinical service which served not only the local Health District but also the surrounding health Region.

Intimations of things to come.

The changes required were massive and at all levels. There were changes in roles, in professional and power relationships, and in management and decision-making structures, not only within the department but between the department and its parent, the Mental health Unit. With the changes came times of crisis and instability. For some this meant welcome challenge, for others unwelcome stress as their jobs had changed in ways they had neither predicted nor wanted.

For those staff who had worked on the alcohol side in the residential hospital base, this meant doing less long term counselling, more crisis work and detoxification, and dealing for the first time with clients/patients who had drug problems and very chaotic lives. This left staff at times feeling de-skilled, lacking in new skills and unsupported.

For those staff who had worked in the drugs side, the changes meant more resources available, less autonomy and more interdependence. There was a heightened role conflict around clinical responsibility which was generated by the introduction of substitute prescribing of legal drugs for opiate dependent and injecting drug users. While doctors prescribed these drugs, it was mostly left to the nurses and counsellors to take responsibility for negotiating changes with the users who frequently sought changes in both the level of drugs and the prescribing arrangements in order to fit in with the frequent chaos in their lives.

A thread running through this fabric was the conflict of interests and styles between the two consultants and it became a major influence on how the changes were managed.

Myself as a 'Key Player'.

I began the job wanting to give myself time to get to know the history of the organisation and how it worked, who the staff were and what their vision of their work was. It was important for me to find out who I could work with easily and at what points could I 'fit' with the staff. I looked for the strengths and the areas of flexibility because I believed these would be important to link with in making change. I decided not to commit myself in the early stages to particular sorts of work, but to involve myself as the opportunity arose in whatever came up in order to do the sort of reconnaissance I was wanting. I circulated a memo advising what I would be doing and what I was available for. I kept a reflective diary to help guide me through this stage.

I was aware that it would be easy at the outset to set myself up as doing psychological treatments in the mainstream tradition of Cognitive-Behaviour therapy, responding to the agenda of the two consultants. However, at that stage, I was the only psychologist, and to take up this invitation would mean I could easily devote myself full-time to seeing long queues of clients and working in relative isolation as a result. I was more interested in how psychological skills and knowledge could be made available to clients in the broadest sense through interactions with all the staff, as well as in the specific and more narrow specialist sense of sessions in psychological treatment. Although I could provide the sorts of psychological treatments advocated by the consultants, I did not wish to confine myself to them. I also believed that other disciplines could be taught many of the more straightforward treatment techniques In short, I was wanting to see what opportunities were available across the services as they developed, and what roles I felt it best to play in order to meet my own aims and also the collective aims of the service as they emerged.

I discovered that there were many different visions of what the changes would mean and that there were conflicts around leadership and power between senior male staff who had more

recently joined the department. There was also a tension between longer term staff and more recently appointed staff, and between medical and nursing staff.

In order to be open to possibilities I had to be careful to avoid covert coalitions. I had more clinical experience than the other senior clinicians and in previous jobs had taken a lead role in developing a service, but I felt I had to mask my experience and skills in order to join with them. I did not feel my inquiry into other's views was often reciprocated, particularly by the more senior of my colleagues - there seemed little curiosity in the experiences I had brought with me as a professional.

So I began the research at the same time as finding my own way in working with people to create a climate which valued co-operation and supported growth and change. Despite the value I place on collaboration and looking for strengths, the reader may note a degree of wariness and scepticism in my descriptions of colleagues. This is how I felt at the time. My characteristic style is to enter new experiences cautiously and avoid getting too heavily engaged with others until I am sure of where they stand and how they view the world. In looking back now, I realise I was picking up on some of the tensions which were later to cause conflict. For example, the senior nurse had been selected by the clinical director against the wishes of other nurses. Neither of the two consultants thought the post of Assistant Director of nursing should have been created. The clinical director did not believe a second consultant post was necessary in such a small department. Some of these issues and my understanding of them will weave their way through the remainder of the research account.

Early Research Questions.

By this time I had made the first links with Bath University, having identified it as a place which offered an approach to research which seemed to fit with my views and interests. My first task was to narrow down the broad questions I was carrying with me. I did not have one clear burning question, nor did I have a clear idea about a project with a clear focus. There seemed to be a certain territory in which my research needed to be located - questions about multidisciplinary teams in a health setting and questions about my role as a psychologist.

The *initial broad questions* I posed for myself were:

- "How do multidisciplinary teams in a mental health setting interact together in the best interests of their clients.
- Can a map be constructed that will guide the development of effective teamwork?;
- What roles, skills ,knowledge and strategies do I as a clinical psychologist bring to bear on presenting client problems being considered by the team?"

To aid my thinking I reflected about my beliefs, assumptions and principles at the time concerning individuals and teamwork. I wrote these down and shared with supervisors and

fellow researchers at Bath as part of our early discussions in orienting ourselves in research. Following is a summary written at the time.

Core principles:

I believe it is desirable that team members take time to develop trust and honesty so that conflict can be resolved constructively and responsibilities shared in an appropriate way. Central to my interest in teamwork is the belief that well-working teams enhance individual effectiveness.

Assumptions about teams:

Teams are likely to function best when:

- Members listen to and support each other, and affirm strengths regardless of status.
- Members share personal goals which are then incorporated into group goals, and these are reviewed regularly.
- Roles are clarified and role boundaries are negotiated.
- There is a shared philosophical base which informs decision-making.
- Decision-making and communication structures are developed which support and ensure each member functions according to their ability.

My reflections and internal dialogue about these statements:

Given that members of different professional disciplines have separate bodies of knowledge and world views, are afforded different status, and have different types of formal power and influence, it is questionable whether multidisciplinary-disciplinary teams can work effectively. However, the potential value of multidisciplinary-disciplinary teams lies in these differences, where different perspectives can enhance the problem-solving and decision-making processes. Therefore, finding ways to enhance the interactions so that positive outcomes are more likely is a worthwhile endeavour - it might clarify the dilemma of 'Is it worth the effort, given the inherent conflict of interests and loyalties?'. If I am to research the possibilities of developing effective multidisciplinary teamwork, then I need to start with clarifying the questions for myself.

The most important questions for myself at this stage are:

- Without formal authority to lead, how do I function effectively to make the process work?
- If I am an equal member of the team, then how can I participate so that teamwork is promoted and we collectively come to understand the process that has occurred?
- What tools do I need to develop so that accurate information can be gathered from all points of view that will lead to the identification and solving of team problems?

- Can I isolate critical incidents or significant parts of the process that lead to a shift in the effectiveness of team-work?
- Can the processes that I and other team members regard as significant be replicated and affirmed as significant by other successful teams?
- How can I present the findings from this team's experience so that new knowledge can be generated?"

This was broad territory indeed. Although I did not recognise it at the time, there was an implicit assumption in these statements and questions that I would be a member of a 'multidisciplinary team' which would be sufficiently identifiable as such, and sufficiently cohesive over time as to allow these processes to occur. There is a tension between these assumptions and the approach I took in the early stages of seeking to work broadly across the department, looking for opportunities to make psychological skills and knowledge available to staff and clients alike in a variety of ways. This is one of several tensions which remained implicit for some time in the research and I will comment on these as I go.

In a subsequent chapter I will present several 'stories' about past experiences which I carried with me into the research. I will use these to illustrate in analogical or metaphorical form some of the frames I was carrying with me into the research and which provide an experiential grounding for the questions I was asking.

In the meantime, having set the scene for my research venture, I will in the next chapter turn to a theoretical and methodological perspective which provides a broad frame for writing the remainder of this research account. It not only informs the final form which this research account takes, but it also informs some of the research activity reported herein.

2. NARRATIVE INQUIRY: A FRAMEWORK FOR WRITING AND A METHODOLOGY FOR INQUIRY.

Introduction

One of the many dilemmas I faced in producing this final written account of my research journey and findings, was to find a form which had a resonance with the experience of the research itself. As the research began to unfold I turned intuitively to a story-telling form in writing as a way of both representing my research experiences and also communicating them to colleagues and supervisors. I started by keeping field work notes, keeping a reflective diary, and writing about incidents within the research setting in a storied form. I found through this process that I became more explicitly aware of the implicit theoretical frameworks, values and assumptions which lay behind the practice I was inquiring into. Thus I learned first hand that story-telling in writing offered a form of inquiry in and of itself. This form complemented the action research methods I describe in later chapters in that it provided a means of reflecting upon and analysing the data generated 'in action' and therefore informing future action. The use of story form and the warrants I used to define a 'good' story, in terms of rigour and quality of knowing, were more implicit than explicit in the early stages.

Towards the end of my research, I was challenged in supervision to make these warrants more explicit. I re-crafted my research writing to do so, making explicit the various criteria I had used over the journey, taking from research theory and methodology as well as from clinical practice. However, I was not fully satisfied with this and read more widely to find a richer and more coherent framework. I discovered that Narrative Inquiry was such a framework, and I was excited to find that this model not only described explicitly many of the things I had been doing, but also named the processes and grounded them in a wider theoretical perspective. I found that it named a process I had been intuitively grasping toward and that it confirmed many of the 'truth warrants' for story writing I had developed for myself.

This gave rise to a second dilemma. In terms of the research journey, it was not a methodology I had explicitly sought out and used in a purposeful way at the outset, testing out its usefulness in informing action and making sense of experience. However , it did inform the final construction of this research account, particularly the last section, and I use it in the last chapter of this thesis in reflecting back over the research journey, in collecting together the different strands of learning. The dilemma arose about where to place a description of Narrative Inquiry for the reader and for myself. To leave it towards the end of the thesis honours its place as emerging in its more explicit form later in the temporal sense of the research journey, but it deprives the reader and myself as writer of a rich framework for rendering an account of that journey.

After much experimentation in writing, I decided to locate this chapter here. It feels risky in that it presumes much of the reader to be suddenly taken into a theoretical framework with little prior knowledge about my intentions as a researcher. It also moves away from traditional

assumptions that a researcher only uses those theories and methodologies selected a priori before the research proper begins (a subject I will return to in more depth in later chapters). On the other hand, it feels a bold and satisfying beginning as a writer and gives more life to the production of this research account. It provides a theoretical grounding for relating a personal and professional journey which in some strong senses is as much autobiographical as it is an account of an inquiry into my professional practice and the organisation in which I work. I see its use here as being a framework for producing a final written account and as being distinct from an explicit methodology for gathering research data along the way. However, this distinction is not a clear one in that story-telling in writing was used by me in a partial and implicit form as a means of reflecting about action and informing further action. I will draw attention to how I do this as I proceed.

I will firstly present the model and then comment on how I wish to use it as a frame for presenting the remainder of the research journey.

A Model for Narrative Inquiry.

The model I will use is taken largely from that developed by Clandinin and Connelly (1994) and I will present this first before embellishing briefly from other sources.

Clandinin and Connelly write from within their interest in personal experience methods in social science and develop a case for the study of narrative as a mode of inquiry. They start from the basis that social sciences are founded on the study of experience and therefore experience is the starting point and key term for all social science inquiry. However there are a range of viewpoints or frames about what constitutes an acceptable study of experience. They acknowledge two positions which they seek to navigate between. On the one hand there is the epistemological position that experience cannot speak for itself, that all we have is a representation of experience in the form of text. Meaning is embedded in texts and in the forms by which they are constructed, therefore the study of texts and their deconstruction is the proper focus for inquiry. The authors see this line of thinking as associated with a sociological and critical perspective, but they see it as risking the affirmation of social organisation and structures, rather than people and their experiences, as the appropriate starting points for inquiry. They refer to this approach as 'formalism'.

As an aside, the authors do not define what they mean by text, but my understanding of the term 'text' as used across interpretive and narrative inquiry approaches to research, refers to more than just written representation of experience. Parker (1992) defines text as " delimited tissues of meaning reproduced in any form that can be given an interpretive gloss" (p6). Within this definition he sees speech, writing, non-verbal behaviour, Braille, Morse-code, advertisements, architecture, and bus-tickets as examples of texts. They may not have an author and they contain and elaborate meanings that are trans-individual.

Returning to Clandinin and Connelly, the other position they refer to is one they call 'reductionism', one that is advocated by those whom Schön (1983, 1991) calls 'technical

rationalists'. Schön uses this latter term to describe the model underlying traditional professional practice. This is a position embedded in the epistemology underlying traditional science (positivism) which sees professional knowledge as instrumental problem-solving made rigorous by the application of traditional scientific theory and technique. From within this position there is a dichotomy between knowledge and its application, between the knower and the known, and professional practice is reduced to skills and abilities in applying firmly bounded and standardised scientific knowledge. This frame of reference argues that experience is too complex, holistic and next to meaningless on its own, and therefore insufficiently analytic to permit useful analytic inquiry.

Clandinin and Connelly seek a position between these alternatives - one which avoids the extremes of formalism on the one hand which remove the particulars of experience, and the extremes of reductionism on the other which reduces the study of experience to the use of skills, techniques and tactics. They propose narrative and story telling as an alternative mode of inquiry, one which places them as centrally involved in the study of experience and at the same time recognising the truths in the above objections. They make assumptions that experience is both temporal and storied and follow Carr (1986) in arguing that when individuals note something of their experience, either to themselves or others, they do so in story form. Stories are the closest we can come to experience as we and others tell of our experience, and they have a sense of being full and of coming out of a personal and a social history. Clandinin and Connelly's standpoint is that story is neither raw sensation, nor cultural form, it is both and neither. They seem to agree with Bruner (1986) who says that experiences structure expressions, but expressions also structure experiences.

This is the authors' point of reference in imagining what experience is and how it might be studied and represented in researcher's texts. For them, experience is the stories people live. People live stories and in the telling of them reaffirm them, modify them and create new ones. These elements interact reflexively with each other.

They see 'inquiry into narrative' as interchangeable with 'narrative inquiry', arguing that narrative is both phenomenon and method. Narrative names the structured quality of experience to be studied and it names the patterns of inquiry for study. To preserve this distinction they retain the device of calling the phenomenon 'story' and the inquiry 'narrative'. For them, people by nature lead storied lives and tell stories of those lives, and narrative researchers describe such lives, collect and tell stories of them, and write narratives of experience.

Narrative terms used in their work include *temporality, scene,* and *plot,* where these work together to create the experiential quality of the narrative and describe where the action occurs and where *characters* are formed and live out their stories. Cultural and social context play a role in narratives, playing constraining and enabling roles for the characters and the action. They borrow from Carr (1986) in structuring time within narrative into past, present and future,

relating these dimensions to three critical dimensions of human experience, 'significance, value and intention.'

They do not elaborate on the meaning of or connection between these dimensions. My speculations (within the metaphor of 'story and narrative') are that past experience gives *significance* to current experience as past stories are elaborated upon or new stories created; that present experience allows both the assigning of *value* to events and also for the values inherent in experience of the individual to emerge through the telling of story; and that the concept of future allows for and structures the notion of *intentionality* or purpose, both implicitly containing a sense of temporality or movement within and over time.

I believe it is important to be aware of the degree to which these concepts of time are culture-bound. For example, the NZ Maori people talk of the past being their future, of carrying their past 'ahead' of them. I do not experientially understand what this means for myself, but know that my sense of time became distorted and confused when working with them and accommodating to their social processes. So while I could intellectually grasp different concepts of time I had much difficulty grasping what this meant at the level of experience, knowing only at this level that there was a difference.

Clandinin and Connelly deal with the issue of the researcher's presence in narrative inquiry through the metaphor of 'voice', and use the concept of *multiple "I"s*. Attention is drawn to which "I" the researcher is using at any one time, the "I" who speaks as researcher, teacher, individual man or woman, participant , narrative critic, theory builder and so on.

In drawing distinctions between different levels of experience, Clandinin and Connelly refer to Dewey's (1938) theory of experience in which experience, life and education are seen as inextricably intertwined. The study of experience is the study of life, for example the study of epiphanies (moments of revelation in a person's life - Denzin, 1989), rituals, routines, metaphors, and everyday actions. Dewey views individuals, organisations and communities as being organisms which have life, with both individual and social aspects, and with inner and (outer) existential dimensions. Although what is studied is a function of the observer's interests, it is these dimensions of experience which are of ultimate interest to narrative researchers.

In writing on interpretive biography as a means of studying individual's lives, Denzin (1989) suggests that it may not be possible to draw such clear-cut distinctions between the different selves, and between the past, present and future as Clandinin and Connelly have drawn them. Denzin comments that in any story told, multiple selves speak, and that these selves are temporal productions residing in both the present and a re-constructed past. "These multiple selves merge, double back, laminate and build on one another, and provide the context and occasion for the larger story that is told. The boundaries and borders between the multiple stories is never clear-cut, for the meanings of every given story is only given in the difference that separates its beginnings and endings from the story that follows. As one story ends,

another begins, but then the earlier story overlaps with the one that is now being told." (p72), To this extent, past, present and future as contained in stories can be seen as productions or creations which may intersect and overlap in non-linear ways.

Despite this caveat, Clandinin and Connelly's conceptualising of the different dimensions was helpful to me methodologically, and it is to this that I return.

Methodological guidelines.

In contemplating the messy complexity of experience, the authors suggest some guidelines for the researcher in navigating their way through. First is the notion that the researcher must constantly attend to the purpose or "the why of the work" (p416) from beginning to end, recognising that this may change according to new stories which emerge, leading to unexpected changes in direction. They comment that in collaborative work this is most likely to become painfully apparent. It is this strand which (paradoxically) defines the starting and stopping points and holds and connects both the expected and the unexpected, the relevant and seemingly irrelevant, and what may appear to be a seemingly endless array of possibilities.

Secondly, inquiry into personal experience is simultaneously focused in four directions: *Inward*, in the sense of feelings, hopes, aesthetic reactions, moral dispositions and so on (internal conditions); *Outward*, in the sense of paying attention to the wider environment, the world of social roles and relationship and the kinds of lives people live (existential conditions); and *Backwards* and *forwards* , referring to the temporality of experience which acknowledges the sense of history and the intentionality of the organism undergoing the experience. "To experience an experience is to experience it simultaneously in these four ways and to ask questions pointing each way." (P416). For researchers there will be an autobiographical quality to their experiences. The stories heard and the texts read will invoke the researchers' own experiential memories with their own temporality, which in turn will influence the meaning made of the events referred to in the texts and stories. The same is true of readers of research texts. In this way, the 'experience of experience' will be multifaceted.

Finally, they offer three sets of methodological questions to help researchers structure the complexity of experience as they find themselves in a "forest of stories" pointing in different directions. One has to do with the field of research experience, another has to do with the texts written and told about the field experience, and the third is to do with the research account. Field, text and research account, and the relations between them and with the participants, name primary kinds of decisions to be made by those undertaking study of experience. I will summarise each respectively and at the same time take what is relevant for my own use.

• The Field (or, 'experience of experience').

Following Dewey, the authors' principal interest in experience is the growth and transformation in the life stories the inquiry participants author. Therefore, no matter how difficult it is to tell a story, the more difficult but important task in narrative is to retell stories that allow for growth

and change. I would add here that this is a presumption that may not be shared by all researchers, and could be seen as screening out certain stories which may be vital for the researcher to hear, and important for the story-teller to relate. Such stories may be ones of pain and oppression, for example, which need to be given voice so that an awareness can be created in others about how they might be participating, however inadvertently, in oppressive practices.

Here, the nature of the relationship between researcher and the field of experience may vary, from being a so-called neutral observer to being a full participant. Whatever the relationship, researchers, as do the other participants, come with stories of their own, already engaged in narrative processes. Together, all partake in the authoring of new stories. All live, tell, and modify through re-telling and re-living, stories which interact reflexively with each other. "We imagine therefore that in the construction of narratives of experience, there is a reflexive relationship between living a life story , telling a life story, retelling a life story and reliving a life story." (p418).

This interactive process constitutes the inquiry. These new stories emerge from the prior stories or narrative processes which all participants bring into the field as they collaborate together. Therefore it is important to be sensitive to these prior stories as they will form the basis of the inquiry and will have varying degrees of influence. One of the starting points for Clandinin and Connelly is for the initiating researchers to be aware of the stories they are living as they enter the inquiry.

• Field Texts.

The authors use the term 'field text' to refer to what is usually called data - that is, journal entries, field notes, photographs and so on. They are texts created by the participants and researcher which represent aspects of field experience. They may have been formed prior to the inquiry or during the inquiry, but become field texts when they become relevant to the inquiry.

The relations between the researcher and field texts involve complex questions of the representation of experience, the interpretation and reconstruction of experience, and appropriate text forms. Researchers try to gain experience of their experience through constructing narratives. It is here that researchers deal with questions of who they are in the field and who they are in the texts they write about their experience of being in the field. "Questions of telling, that is, of the research account, come down to matters of autobiographical presence and the significance of this presence for the text and for the field. Matters of signature (Geertz, 1988) and voice are important" (p418).

Getting from field to text is a critical matter and an important factor in this is the nature of the relationship between researcher and participants as this establishes the epistemological status of the field texts. What is told, as well as the meaning of what is told, is shaped by the relationship. The authors assume that a relationship embeds meaning in the text and imposes

form on the research texts ultimately developed. The field text created may be more or less collaboratively constructed, may be more or less interpretive, may be more or less researcher influenced. The authors believe serious deceptions can occur unless the relationship between researcher and participants is clear and unless the method for moving from field experience to field text is clearly explicated.

Field texts can take various forms, each with their own methodology and body of literature. Clandinin and Connelly list some as follows:

- *Oral History, Annals and Chronicles.* These are methods in which the researchers' intentions are uppermost and represent a range of strategies for having participants re-collect their experiences. Within this range the researcher can shift the focus from information gathering, in other words asking the right questions, to interaction where the focus is on the process. The account obtained is but one of many possible representations of the participant's life.
- *Family stories.* These are related to the above, where the focus is on family stories handed down through the generations. These have both internal and external or existential conditions, relating to experience within the family or to how the family engages with the wider world respectively.
- *Photographs, Memory boxes, Personal/family artefacts.* Each item marks a particular time, place or event around which a story is told.
- *Research Interviews.* These can be turned into field texts through transcriptions, note taking and/or the selective use of segments of the interview.. The way the interviewer behaves within the interview, selects and structures the questions and provides a frame within which participants shape their accounts of their experience. Culture and gender differences influence the way participants experience research interviews.
- *Journals.* This form of text within research are records of practices and reflections on those practices, weaving together the private and the professional, capturing fragments of experiences in attempts by the authors to "sort themselves out" (p421).
- *Autobiographical writing.* An extension of the above form, autobiographical writing moves from the fragmentary day to day experiences to a wider life context in which the individual captures the tension between self and others. Again this is a telling of one of a range of reconstructions, and the autobiography can be seen as a 're-telling' as life (within the narrative metaphor) is already a kind of narrative construct (Molloy, 1991).
- *Letters.* Unlike journals, letters are written to a specific 'other' with the expectation of a response. "In letters we try to give an account of ourselves, make meaning of our experiences, and attempt to establish and maintain relationships among ourselves, our experience, and the experience of another." (p421). One of the merits of this form, suggest the authors, is the equality established, the give and take of conversation.
- *Conversations.* This is a more generic form of activity, representing a less constraining and more equal and flexible form of encounter between participants where a fuller co-

authoring of the form and topics of conversation is possible. Again, the nature of the relationship between researcher and participants creates one of the contexts in which meaning is constructed.

- *Field notes and other stories from the field.* These are considered to be the mainstay of ethnographic data collection methods and may be written by researchers and participants, in more or less detail with more or less descriptive content. Providing the nature of the relationship between researcher and participants is made clear, Clandinin and Connelly advocate bolder use of field records. As all field texts are constructed representations of experience, there is no reason, they argue, why field notes cannot capture experience as adequately as tape or video recordings which give rise to penalties in transcription at a later stage.

• Research Texts.

Although field texts may be rich and interesting in their own right, they need to be reconstructed as research texts because the task is to discover the meaning and social significance contained therein. Research texts are at a distance from field texts and grow out of the repeated questions concerning meaning and significance. A research account looks for patterns, narrative threads, tensions and themes either across individuals or within individuals' personal experience.

The search for meaning is created by the researcher's experience, and this has both internal and existential conditions. Just as the researcher's relationship to participants shapes the field text, so too does the researcher's relationship to the participants and the inquiry shape the research text. The authors take the position that who the researchers are makes a difference at all levels of the research and that their "voice" and the "signature" they put on their work comes out of the stories they live and tell. The researcher's "internal conditions of experience" (p423) therefore are of as much relevance and importance as the "existential conditions" which occupy so much of the space in traditional research. These then are two further sets of methodological questions for the researcher to consider.

• Internal conditions

The metaphors of voice and signature are two significant ways in which the researcher is present in the research text. The authors acknowledge the developing literature on voice and describe voice as an acknowledgement by the researcher that they have something to say. The beginning researcher may move from a position of silence, from merely summarising and rewriting others work, to a position of independently having something to say on their own behalf.

For the experienced researcher there are dilemmas about voice in moving from field to research texts, balancing their own voice with those of the various participants. They must also balance that which is said with that which is not said, the implicit versus the explicit, and to be aware that as researchers they can have multiple voices as well. The other side of voice is

silence, some of which is present in an aware and chosen form, some of which is present in an unaware form. Temporality is another issue of voice which needs to be made apparent. Is the voice a current voice, speaking about how things seem from the present, or an historical voice, speaking about how things seemed at some point in the past?

How the researcher expresses voice in their own unique way constitutes a closely related metaphor of signature. Clandinin and Connelly refer to Geertz's (1988) concept of "being there in the text" as signature, denoting the particular forms the researcher has found among the many available for signing his or her presence. There are also dilemmas around signature as there are around voice. If a signature is too flimsy or thin then the ensuing text risks being signed by other texts such as those coming from theory. If it is too vivid then it risks the charge of being overly subjective and not conversing enough with other texts, thus obscuring the field and other participants.

The text which follows from the signature has a recognisable cadence, rhythm and expression which mark it as coming from a certain author or group of collaborators. Geertz calls this expression of signature "discourse". The signature and its expression in discourse creates an author identity.

• Existential conditions.

Clandinin and Connelly consider three existential conditions to be of importance to personal experience methods in moving from field text to research text. They are *inquiry purposes, narrative forms,* and *audience* and the researcher's imagined relationships to them.

- *Inquiry purpose* - or the question 'what are we doing here?' - comes to the fore in writing the research text. Here the researcher is writing not only for the self but also for others in the hope of influencing discourse and practice in a wider arena. Personal experience methods have the potential to transcend the specialities of research in a particular subject, to connect with fundamental qualities of human experience, and to relate to wider life communities.
- Differing *narrative forms* are increasingly being used to relate findings in research texts, including visual, poetic and dramatic forms. Borrowing from and adapting of signature of favourite authors is warranted in finding one's own unique form.
- In writing for a wider *audience*, texts may be descriptive, expositional, argumentative or narrative. All of these texts can be used, depending on the imagined relationship the researcher wishes to enter into with audiences. Clandinin and Connelly advise researchers to imagine themselves in conversation with an audience and ask, 'what kind of voice and signature shall I adopt - what kind of conversation do I imagine will ensue?' The authors advocate that in this way personal experience methods offer the opportunity to enter into conversations, through texts, with the wider social world in such a way that transformation and growth can occur.

These methodological guidelines lead on to questions of validity, or quality and rigour of knowing - in Narrative Inquiry terms, what constitutes a 'good story'. Before gathering some validity criteria for my own purposes, I wish to pause briefly to consider the nature of experience as implicitly framed by Narrative Inquiry.

Is there more to Experience?

Clandinin and Connelly do not elaborate about the domains in which 'experience is experienced', but their frameworks too easily suggest it will largely be that of language. Whilst I agree that we mostly resort to linguistic domains when we come to name experiences and communicate about them, I feel it is important to leave the wider field of experience open to include non-verbal dimensions of experience. Otherwise there is a risk that dominant ways of knowing will inadvertently be allowed to prevail at the expense of others. I will refer briefly to several sources to illustrate.

For example, Heron (1981,1992) develops an extended epistemology in which he proposes different forms of knowledge. I will draw upon this in more depth in later chapters, but will briefly introduce it here in order to make the case for extending the types of experience to be included in any experiential inquiry. Heron's 'propositional' knowledge domain is that of propositions, statements, laws and theory. This form of knowledge is the main kind of knowledge accepted in our culture and requires mastery of language to express its concepts. While this is an important domain, an over-reliance on it leads to isolation from other ways of knowing which are in the realm of the symbolic and the intuitive as well as the practical. These latter forms are tapped by Heron in his 'Presentational' knowing (occurring through perceptual imagery leading to awareness of metaphor and symbol), 'Experiential' knowing (knowing an entity through encounter, drawing on the tacit or intuitive), and 'Practical' knowing (knowing 'how', embodied in skills and proficiencies).

In considering biographical texts as narrative devices for the expression of an individual's life, Denzin (1989) describes experience as individuals meeting, confronting, passing through, and making sense of events in their lives. He cites Bruner (1986) in observing that experience refers to how the "realities of a life present themselves to consciousness" (p33). Denzin categorises experiences as either problematic, routine or ritual-like. Problematic experiences are termed epiphanies or moments of revelation in a person's life, where individual character is revealed as a crisis or significant event is confronted and experienced. He notes that the expression of experience can occur in many ways including rituals, song, literature and dramas performed. The various forms of expression are shaped by cultural conventions and are given life through performance. As experience is performed according to cultural and social texts, those texts come to constitute that experience. Expression of lives as performed texts become socially constructed structures of meaning (Bruner, 1986). However, this seems to me to begin to lead towards the formalism Clandinin and Connelly seek to avoid, whereby texts rather than people and their experience become the focus of inquiry.

Reason and Hawkins (1988) write about story telling as a qualitative method of inquiry which can potentially capture the liveliness, involvement and passion of researchers' lived experiences. They use story-telling as an explicit and creative metaphorical process among a group of researchers engaged in Cooperative Inquiry (a form of inquiry which I will describe in Chapter Four), but nonetheless their comments on the nature of experience are relevant to my purpose here. They see story-telling as one of many cultural forms available for the expression of experience, alongside myth, art, dance and poetry. They acknowledge many languages in which meaning can be expressed and communicated - the languages of words, actions, shapes, colours, silences and stillness as examples. They note that languages are analogic and symbolic and do not point out meaning directly but rather demonstrate it by re-creating pattern in metaphorical shape and form. They also note that story telling as they use it maps onto Heron's domain of Presentational knowledge.

My intention here is to signal the importance of multiple forms of knowing as necessary 'media' for experiential inquiry, allowing and enabling the participants to engage fully and holistically in those aspects of life they wish to investigate. I explore these epistemological issues and their relationship to various methodologies and associated criteria for validity in later chapters. However, while still resting with Narrative Inquiry I would like to derive some criteria for validity, or quality and rigour of knowing, from within this framework. In order to do so I need to introduce in summary form some of the major issues which arose for me in conducting the research - these will provide a 'frame' for guiding my selection of narrative quality criteria and how I see them as being useful for the production of this research thesis. While such a step here risks pre-empting the unfolding story of my development as a researcher, with its personal sense of being a journey, I feel it is necessary to give some idea of how the narrative inquiry method fitted my personal experience and hence gained much utility in informing the writing of this final research text.

Narrative Inquiry as a 'Framework' for writing.

One of the narrative themes in this account is the sense of personal and professional journey I experienced in undertaking research. Therefore I will be telling of my search for the key questions I wish to ask, of my search for theory and methodologies to carry these questions, and of my developing awareness of different ways of 'knowing' about experience. Part of this will be my growing awareness of the use of story and the various warrants I develop for its use.

As I began the research I became aware of many past experiences I was carrying with me which influenced the questions I was asking as well as my day to day practice. In Clandinin and Connelly's terms, these were the stories I was living as a researcher in entering the research. I also carried hopes, visions and aspirations for the future, partly based on the 'stories I was living' and so my experience had temporal dimensions. My personal experience of engaging with the research was one of becoming more highly aware in day to day practice of the theoretical and value assumptions I was carrying. Furthermore there were incongruities

between my intentions as a researcher and my day to day experiences which gave rise to painful dilemmas. Writing about these experiences in storied form facilitated my growing awareness and helped with the eventual resolution of the dilemmas.

Philosophically I was drawn to action research methodologies with their preference for knowledge gained in and for action, and with the researcher as full participant. I was also drawn to constructivist and social constructionist epistemologies which place individuals as being fully involved in making sense of and constructing meaning about their worlds. In research terms both preferences place researchers and their own personal processes within the field of inquiry.

This focus on personal process constituted an inward looking dimension to the research, one which was facilitated by writing about my experiences in the field in storied form as I went along, This writing was a means of making explicit to myself my own personal processes as a researcher and how they informed and were informed by the research process. In turn they also became a means of communicating with others about the unfolding research process.

Additionally, these methodological and philosophical preferences required a rich description of the research setting and the individuals who people it. If knowledge is socially constructed, then an account of the relationships and the contexts within which meaning is ascribed is vital. This gave rise to questions for me about authentically representing others in my research accounts and honouring their views as I understood them to be. Furthermore, my research is partly an inquiry into organisational life and thus an appreciation of its history, its development over time and its relationships with its environment became important. In this way the research gained an outward (or in Clandinin and Connelly's terms, 'existential') dimension.

Finally, the research process led to experiences of painful confusion and challenge, and eventually transition and growth. The process of writing about these experiences, as dialogues with myself, experience and theory, facilitated the transitions as much as did acting in the world and dialoguing with others. I came to see story telling as complementing action inquiry methodologies by providing a form of reflection-for-action, linking reflexively with the reflection-in-action required of and facilitated by action inquiry. I pursue this in Section Two.

It is against this background that I have selected the list of narrative criteria below for informing the presentation and construction of this thesis. In thinking about how I could use a Narrative Inquiry framework to inform the construction of a narrative about the research, I selected out what I thought to be those key characteristics of the framework which described my own experiences of finding a form of representation of experience in writing, and which mapped onto or intersected with my own set of quality criteria (developed in chapter five). I see these characteristics as addressing both validity considerations (the quality of the knowledge gained) and methodological considerations (the rigour with which the researcher goes about finding out). These criteria helped me create a narrative about the research which represented my experience as authentically as possible within the domain of writing.

Narrative criteria for quality.

- A well crafted story has plot, characters, a sense of temporality and has both inner and outer or existential dimensions.
- Stories are about moments or processes of challenge, growth and transition, and the meaning taken from them is presented in the research narrative.
- The purpose or the 'why' of the inquiry is present, either implicitly or explicitly, in or around the story.
- The relationships between participants and researcher is made explicit in the research text.
- The researcher pays attention to and makes clear the stories she/he is living as she/he comes into the inquiry.
- The author's presence is discernible in terms of voice and signature, and the framings from the different perspectives of the multiple "I "s are explicit.
- How the researcher and participants move from field to text to research account is available to the reader.
- There is a balance between the researcher's voice and the voice of others from the field of research, including other authors.
- The research text shows an aliveness to silences or absences or stories not told and the possible meaning to be taken from them.

The Narrative Inquiry framework I have sketched out will provide a position from which I can comment from time to time on this research journey as it unfolds. To the extent that this framework is 'embroidered on' to the beginning end of this thesis, the thread of commentary I make from within it will not always be easily woven into existing fabric. This is one of the ways in which it feels risky to structure the writing in this way and it feels proper to acknowledge this here. However, this risk is offset by the value for me contained in the recognition the framework gives to the complexity of experience, and the sometimes difficulty of recounting it and accounting for it. The metaphor of the researcher at times becoming lost in a 'forest of stories pointing in all directions' is most apt for my experience in conducting the research and making sense of it.

I will use the criteria above to guide myself and the reader through the remainder of this research 'narrative'. Sometimes my use of them will be implicit and the reader may be more aware of them than I as the writer. At other times I will refer to them explicitly when I wish to add a researcher's voice on issues of rigour and quality of knowing, or when I as writer wish to assist the reader as audience through complexities of my own experience. In the final section of the thesis, I will directly refer to how I used narrative inquiry to select 'which stories to tell' from the many I had collected as field texts.

In the next chapter I begin with telling stories which, in Clandinin and Connelly's terms, are some of the stories I am living as I enter the research.

3. STORIES FROM NEW ZEALAND.

Introduction.

In this chapter I will tell several stories from my professional life in New Zealand. I include them here to illustrate some of the issues I was grappling with in my practice over the years which led me to the question at the heart of my entering research - 'What was it I did that contributed to successful outcomes in practice?' This question did not seem to be in a form which lent itself to being easily researched, at least not within the forms of research that I was aware of. It was also a question which was more often implicit than explicit, being intertwined within many other questions in a buzzing confusion.

The stories I present here are only several of the many I carried which were 'alive' for me as I entered the research field. As I searched for clarity of focus in those early days, through reading literature on research theory and methodology, through noticing my current practice, through discussion and through keeping reflective diaries, I found these stories from the past stayed with me, seeming to either resonate or contrast with current experience. As I began to start writing about my research, for discussion with fellow researchers and supervisors at Bath, I wrote of some of my New Zealand experiences at the same time.

I wrote intuitively in storied form although I had no explicit sense at that stage of what constituted a 'quality' story. I also discovered the potential for story telling as a form of inquiry, as in the telling about prior experiences I became more fully aware of their significance for me in my current professional life and how they were informing the sense I made of current experience. Whilst these stories must be seen as reconstructions, influenced by the current context in which I was writing them, they nonetheless seemed 'present' with me at the time of writing. In Narrative Inquiry terms, they represent some of the stories I was 'living' as I entered the research field. Writing about experiences in storied form was the beginning of a process which emerged to become increasingly explicit over the course of the research.

In the stories presented here I do not attempt to tell of experiences in all their complexity, but rather I select those dimensions which hold together as one or more threads connecting experience together over time in a pattern which contain particular meaning for me. In the telling of them I attempt to give just sufficient background information about the setting and the people involved so that the reader can see how I take meaning from them. It is a difficult balance to achieve and these stories have come through many re-craftings in an attempt to convey 'essences'. I have successively 'thinned' them out so as to not leave the reader wandering through dense detail unsure of what they are meant to be noticing. This process of re-crafting can go on indefinitely, so the stories I present here are in the form of 'this is good-enough' to carry what I want to say. I have had to resist strong temptations to make the descriptions 'thicker' to convey complexity as I experienced it. These stories represent my first attempts at writing in a form which I did not recognise formally as 'story-telling' therefore I have

resisted the temptation to embellish them further from within my later-arrived-at appreciation of Narrative Inquiry. I include them as written in the earlier stages of the research journey, although no doubt they have received some 'polish' from my later knowledge in the final draughting of this research account.

These stories remained alive for me in a second way as I entered the research. Jan and I had shared many professional experiences together and had used each other for personal support in talking through difficult or challenging times. This was particularly so in relation to working with the Maori people where we had both been involved, although in different roles. Now that we had some distance in time and space from New Zealand we 'de-briefed' together frequently about these experiences, making new sense from our new vantage points provided by another setting in another country.

I would like to present several of those stories now as experiential grounding for later writing and as analogical or metaphorical representations of the practice and research issues I was struggling with. *The core theme of these stories which I wish to highlight is how I was implicitly searching for a way of understanding and accounting for what I did in practice.* I found myself in many roles and situations for which my training had not equipped me, for which I had only very limited theoretical or practice frameworks informing what I did. Those frameworks I used came from therapy frameworks, often family therapy. The rest came from my own personal values, from intuition and guesswork, and from discussion and analysis with those in personal and professional networks who shared similar interests. It was the need to find a more coherent set of frameworks to account for what I did which provided one of the motivations for research. I am hoping that these stories will embody this for the reader in a richer way than a mere statement of 'fact' or intent. I will pause at the end of each story to describe what I take from it.

The first story is an account of looking for ways of practising authentically, attempting change in the way I and others practised in a multidisciplinary team setting, and failing in this. It is also about encountering the different interests and world views of the professional groups in a mental health service and my beginning awareness of how they influence relationships.

Lessons in initiating change.

The setting for this story is an acute admission ward in a psychiatric hospital in Auckland, New Zealand. I had been qualified for three years and I had not long moved to this job from a one in a community service for people with alcohol and related problems. Although I had worked before in acute admission wards, it had been during training and hence in a very junior role. I had moved to this job because of the connection it offered with a community mental health centre which served the same catchment area as the ward. This centre provided a complementary service to the hospital by seeing clients in crisis in order to minimise inappropriate admissions. The staff there had developed a network of statutory and voluntary

workers and agencies, and together they provided support to people with mental health problems within their own family and community settings. They had been successful in reducing hospital admissions with the result that very few came into the ward from there. Their other role in relation to the ward was to provide follow-up care after discharge for patients who lived in the area.

Several staff at the centre were family therapists and had started training a small group of mental health professionals, of whom I was one. Taking the position on the ward allowed me to negotiate a small role in following up patients at the centre after discharge from hospital. In this way I could get live supervision from the family therapists as part of my training. Jan was the co-ordinator of the centre, being the person who had set it up from scratch, and so it was also an opportunity to find a small niche in which we could work together with families.

I was apprehensive about working again on an acute psychiatric ward. I did not relish being back in the 'institution' where the focus was more likely to be on 'controlling the symptoms' and 'treating the illness' from a medical perspective, and less on developing an understanding of the person in the context of their life and involving family and significant others in the process of change. I was worried about how I could contribute a psycho-social viewpoint in this setting and also be seen as useful. More generally I was seeking ways of developing my identity as a psychologist: respecting the needs of individuals while at the same time addressing issues in their social context which seemed to contribute to their problem. Family therapy, with its emphasis on seeing problems as occurring within the social context of the family, seemed a way of partly resolving this dilemma. So, going to work in a hospital setting both gave rise to contradictions for me, but paradoxically also offered a way of doing 'both/and' by allowing me to have access to family therapy training and experience.

After being on the ward for a few months, I realised that there were few clear expectations about what was required of me as a psychologist. It was a relatively short-stay ward, patients staying no more than three to four weeks on average before moving on. On admission the focus was on arriving quickly at a medical diagnosis, starting medication immediately and then monitoring symptoms. This process involved doctors and nurses who then had a primary role in shaping what sort of service patients received. It was only towards the end of the patient's stay that nursing and medical staff began to think about wider psycho-social issues and start involving myself, social workers and others in preparation for discharge.

This left little time for the rest of us to do anything effective towards the patients stay before they were discharged, and had the more subtle implications that the patients' problems were due solely to illnesses for which the only or major treatment was medication. This was not to deny that many patients did not require or benefit from medication. Many arrived at the hospital in floridly disturbed states, highly agitated, unable to think clearly, deprived of sleep and with families and carers at the end of their tether. However, the process by which patients were dealt with left me feeling on the 'outside', and also concerned that it promoted a passivity

in patients who might be left feeling there was little they could do towards regaining self control over their lives. It seemed that increasing my role in providing follow-up help after discharge was the most pragmatic solution. However, the hospital staff were reluctant for me to do this, they were clear when I suggested this that I was needed on the ward to make the team "multidisciplinary". But, discussing patients at ward rounds seemed to be the only explicitly valued role. I did not enjoy feeling I was a 'token' psychologist. I wondered how I might get involved earlier in the patients' stay and bring a consideration of the psycho-social dimensions alongside the biological: to increase my feelings of effectiveness; to broaden the focus for the patient; and to give more time for the non-medical staff to do their work.

I talked this through with Jan who had long experience as a senior nurse in in-patient psychiatric settings earlier in her career, and she suggested I talk with another psychologist she knew who had faced a similar problem in another hospital. I met with him and learned about how he had started a 'Goal-oriented Assessment Scheme', which involved meeting with the patient on or shortly after admission and gaining their view of the problems they faced in the various domains of their lives. Then, from this assessment, goals were derived with the patient in specific and concrete terms which would represent a resolution of these problems. Once the goals had been prioritised, then staff members with relevant skills and resources would be assigned to work with patients as 'therapists', according to the nature of the particular problem. The patient also had a 'mentor' whose job it was to monitor and review this process regularly and to advocate for the patient if changes were needed in the process, or if new goals emerged.

This scheme seemed to offer all that I was looking for and I began preparing to try it in my own setting. I read around the subject in the professional literature, shared the ideas with the social worker and occupational therapist on the ward and gained their agreement. I next approached the nurse in charge of the ward and several of the medical staff. They could 'see no objections' to the idea. I seemed to have a mandate, so arranged to give an in-depth presentation of the whole process to a staff meeting. In preparation I developed training materials, guidelines, processes and procedures so that I could demonstrate exactly what was required.

From that meeting I gained the agreement of the nursing staff to be a part of the process. There followed several long discussions which resulted in the nurses agreeing to be mentors because of their close involvement with the patients, but also taking therapist roles with any problems requiring their particular skills or interests.

The scheme failed. A considerable amount of time was needed for planning and monitoring after the initial assessment, to ensure that needs were matched with appropriate resources, and to ensure that we co-ordinated our activities with each other. This could not be done in ward rounds which was the existing forum where members of different disciplines met to discuss patients. There the process was organised around consultants training their junior

doctors and the priority was to present information to assist decisions about diagnosis or prescribing of medication, leaving little time for other issues. The nurses were reluctant to challenge the way those meetings were organised and felt they had to give them priority. While the doctors agreed in principle to the assessment scheme and the multidisciplinary involvement it offered, in practice they were indifferent to it and ignored the scheme as being peripheral to their work.

We had to meet outside the ward round. The nurses attended when they could but were frequently not there. The social worker, occupational therapist and I persisted for several months, meeting mostly on our own. We were identifying problems but did not have the necessary resources between the three of us to deal with them all. This created ethical difficulties in raising patients' expectations which could then not be met. Increasingly I felt the other two looked to me to supply the energy for success. I was not prepared to continue in this way and was frustrated and dismayed. At this point, the social workers in the hospital decided as a group to withdraw from playing a role on wards as integrated team members. They preferred to work from their own department and take referrals for any work the nursing or medical staff identified. This appeared to be their solution to the problems they saw inherent in multidisciplinary teamwork. I did not agree with this as a strategy, because I saw them as having even less influence on the way patients were treated or cared for. The occupational therapist and I agreed to stop the scheme and its demise went largely unnoticed by nursing or medical staff.

Lessons taken from this experience.

I was most powerfully aware at that time of the mutual dependence between doctors and nurses in a hospital setting. The doctors' priority was to diagnose and prescribe treatments. This meant they relied on nurses to observe patients, dispense medication and gather information for them. This delegated role meant that nurses became limited in the degree to which they could exercise their own independent roles in carrying out nursing care. The bulk of their work relied on the sanction of the doctor and so they became dependent on them for decisions. In turn this meant that they were even more limited in carrying out inter-dependent work with other disciplines. The resulting relationship struck me at the time as a 'dance' between doctors and nurses which left other disciplines as 'wallflowers', required to be there as occasional partners, but largely onlookers.

My later experience at the community mental health centre gave me a contrasting view as I worked with nurses who had a strong sense of their independent and inter-dependent roles. So I came to see that the hospital setting, and the primacy of a medical viewpoint which prevailed there, created a context in which those particular 'dance' relationships between the disciplines survived.

In relation to my own role, I was clear that I had failed to convince others of the efficacy of what I had proposed. I had relied on my position as a psychologist to introduce a programme

which seemed to meet all the requirements. It met patient needs, used the resources of all the staff, had a theoretical rationale and was supported by the research literature. Yet that was not sufficient. Despite my analysis of staff relationships in that setting, I was still left feeling as if I had personally failed. I had not been persistent enough or worked hard enough, and nor had I been skilful enough.

However, I must also acknowledge a personal agenda which no doubt contributed in some way. I was keen on working more closely with the community centre and developing my skills as a family therapist. Over the succeeding year I spent increasing amounts of time working at the centre with patients and their families. As patients neared discharge from the ward and were identified as needing psychological treatment on follow-up, I would arrange family meetings on the ward and negotiate their involvement for on-going work. I felt able to do this because, after all , I had tried to do it differently, had had a go at being an effective member of the ward multidisciplinary team. But this did not feel a fully authentic conclusion. I did not feel comfortable with the climate of alienation which existed in psychiatric wards.

Caught between cultures.

This story follows on from the first, but several years on in time. I had left the job in the hospital to work in a voluntary agency which had hired me as its Assistant Director, to set up a family therapy service and train several of the staff there to work with me. There were other responsibilities which went with the job, including provision of some of the more mainstream services expected of a psychologist such as group and individual therapies. I saw this job as offering several opportunities: to contribute to a widening network of community mental health services which offered alternatives to institutional based care; to work in a more flexible organisation; to practice more explicitly as a family therapist; and to develop some management skills.

This story is about one management task I was asked to take on as part of the new job. It was to co-ordinate a project to produce a cross-cultural handbook for health and welfare workers. This had been started by the previous incumbent in the job but needed considerably more work to complete. It was intended as a guide to help people in health and welfare organisations become more knowledgeable about, and hence more sensitive to, the beliefs and practices of the different cultural groups living in Auckland. These included the indigenous Maori people, most of the Pacific Island peoples, and people from Asia.

The handbook was a response to increasing awareness within New Zealand society that minority cultures were disadvantaged in getting an effective service from health and welfare agencies. The handbook project had been based on an assumption that increasing the 'cultural awareness' of individual workers about health beliefs and practices of different cultural minorities would improve the services delivered.

The more I learned about what had been developed so far, the more I became worried about the likelihood of success. I had been developing an analysis of New Zealand society which was very influenced by radical Maori groups who were gaining in voice. Their view was that as 'people of the land' they were the host culture, but through colonisation had lost sovereignty over their land and their culture. The Europeans ('Pakeha'), although the dominant culture, were visitors. So too were Pacific Islanders, even though they shared the same cultural roots as Polynesian people. All visitors had a homeland in which their culture was intact. If they were to stay in this country, then they must allow the Maori people to regain sovereignty and work in partnership with them. Otherwise, went the more radical of the Maori groups, 'go back home!'. Failure to change would result in the death of the Maori culture and with that an even greater increase in the growing tragedy of illness, alienation, violence and crime among Maori people.

Stemming from that analysis, the target for change was not so much individual racial prejudice, but instead, institutional racism. The challenge was issued for Pakeha people to become aware of the fundamental assumptions about the world which made them blind to the ways of the Maori, and hence informed practices which contributed to continued oppression. This must lead to Maori people being given their share of resources and access to decision making on terms which fitted with their culture. This was not an analysis accepted widely by either Maori or Pakeha people at the time. For most, the Maori had been given equal opportunity in this society and failure to thrive must be laid at the feet of the individual.

However, I was part of a growing segment of Pakeha society which found the sovereignty analysis both compelling and challenging. While I could not be responsible for one hundred and fifty years of history, I could at least accept responsibility at a personal level for remedying this in the present. I did not know clearly how that would translate into practice at that stage.

Against this background I took on completion of the hand-book. At the outset I thought in principle I could support its production as potentially part of a wider change. However, I rapidly developed misgivings. For a start, it seemed it had been initiated on the wrong basis. My predecessor was originally from Hawaii and had based this current project on an identical one developed there. He thought the idea could be transplanted to our local setting with very little adaptation. He had enlisted the support in Auckland of the director of a local Pacific Island Education centre, a Samoan with european educational qualifications. This man had promised to edit the book while my agency had agreed to obtain government funding to employ workers from the different cultural groups to write a section each on their own culture. Funding had been obtained on a non-recurring short-term contract from the Labour Department, under a scheme to support unemployed people to re-skill in order to return to paid employment. My job was to recruit the workers and support and resource them in collecting the data and writing up. The job of the Director was to edit the work on completion and publish it, using the resources of his centre.

I immediately saw problems with this. There had been no consultation with the various cultural groups who were going to be represented in the book and I worried about how it would be received and whether they would have a sense of ownership over the information presented. I also knew that the education centre was held in suspicion by most cultural groups. The director was Samoan and was seen to favour his own people over other pacific groups, so this mitigated even further against any eventual broad acceptance of the hand-book. Even within his own people, he was not seen as widely representing them. He was a western trained anthropologist, not someone who held leadership by virtue of tribal or church position.

There appeared to be no planning for involving the indigenous Maori people who I believed ought to have the major role in this. They were the 'host culture', they were by far the largest and most complex group with many different tribes, and were most in need in terms of health and welfare problems. With this in mind I set about finding out who the leaders were in the local communities. This was easy enough for some of the smaller pacific island groups who had formed relatively cohesive urban communities since arriving in Auckland over the last twenty years. It was much less easy for the Maori people. They had been a rural people who had drifted into the cities as rural employment and housing had dwindled over the last fifty years. As a result they were alienated from their tribes which were linked to specific geographical areas. Their historical inter-tribal rivalry and conflict mitigated against them reforming into cohesive urban communities. They were also isolated from extended family structures which were part of the bedrock of their identity and well-being. The tribes which were historically connected to the land around the Auckland region had fared worst through the last century and it was many of their people who were over-represented among welfare recipients and occupants of local prisons, psychiatric hospitals and children's' homes. I had to turn not to tribal leaders, but to those individuals, such as Maori welfare workers, who had assumed leadership in the city by being spokespersons for the most disadvantaged groups. I knew of one such person already and turned to him as a support and as someone who could locate researchers on behalf of local Maori people. He nominated his niece.

I started with a small group of people, one Maori and several from the different Pacific Islands. Immediately there were difficulties. There were problems with written literacy as all came from oral cultures. They did not gel as a group because of cultural rivalries so I worked with them individually. They had different senses of priority and time and so it was hard to retain regular contact with them within my time frame. I believed that if the product was to be owned by them, then I had to respect cultural difference and go with the process by which they seemed to work. Privately, I was unsure what the outcome would be, but as I had accepted the task and had embarked on it this particular way then I had to follow it to its natural conclusion.

Shortly after we began, I was approached by the Director of the Pacific Islands Education Centre. He wanted to know what progress I was making and wanted to suggest people he knew who could write the book. He did not envisage that the Maori people should have any

greater space than the other pacific groups. I told him of my views and of what I had done so far. If the people he wished to recommend had the confidence of their own people then I would be happy to employ them.

The director then told me I was "foolish" and there was no way that I would ever get the book published under those conditions. Furthermore, the Maori people had had their chance in this society and had "blown it" because they were "lazy". It was now the turn of the Samoan people and they would succeed and take their rightful place as the strongest group. It was they who would succeed in educating their children and get the jobs and take leading roles in business. I was taken aback - I knew of tensions between the two peoples but had never heard it stated so baldly. I thoroughly disagreed. He said I would fail in producing the hand-book because I would find no one who was capable of writing it. I partly suspected he was right but was absolutely clear in my mind that unless we started from a basis of consultation, the end product would be useless. We parted on unhappy terms but I was convinced I had to do it according to the principles I had started with. I kept my employers informed about developments and fortunately they were able to support what I was trying to achieve.

Concerned about the director's attitude and the effect it may have on the project, I sought guidance from the Maori leader and he contacted others in his network. I met with them and faced their anger that they had not been told of the existence of the book at the very outset of its inception. In particular, they believed as 'people of the land' that they should be exercising leadership over any such project. Eventually, they arrived at a solution. 'Leave him to us, if he causes any fuss, we will deal with him! Let him take charge of the Pacific Island chapters if he insists.'

I proceeded with the project, but inevitably it ground to a halt. Two chapters had been completed about small island groups but I had lost contact altogether with the Samoan and Maori researchers. After discussion with the two remaining researchers we agreed they should seek guidance from their community and I would do what I could to assist. So while I had failed to meet the original agenda of my employers in providing a hand-book for which they could take credit, I felt I had done all I could to maximise the involvement of the different groups. At the same time I felt I had also honoured as far as I could at a personal level the Maori regaining sovereignty over their own culture. I was sad at how fragmented they had become.

Six months later, the young Maori researcher came to visit me. She explained she had been ill for a long time, ending up in hospital with a mysterious illness for which there had been no clear diagnosis. After many weeks in hospital, she had received a visit one night from an old Maori man, a stranger to her. He told her that the knowledge she had been collecting for the book was sacred knowledge and should be kept secret from the pakeha lest their people lose even more of their 'Mana' (roughly equivalent to power, status or prestige, in both a social and a spiritual sense). She was shaken by this, particularly when upon asking the nursing staff

about her visitor was told no such person had been there. She realised it was a vision and that she had met one of her ancestors. She shortly became well enough to leave hospital and was now letting me know that she would no longer be working on the book. From now on she was to live with her grandmother up north and learn the old ways of healing. I was very moved by her story and felt this outcome alone vindicated the process we had gone through.

Lessons taken from this experience.

There were many occasions during this experience when I felt out of my depth and unsure of what to do. It was like taking a journey blind folded. I felt bruised by tripping over the multiple and conflicting expectations I perceived from different groups. I wished to help with a product which gave everybody a voice, but I also wished to honour what I had heard the Maori asking for. I believed strongly in the 'truth' that the Maori people must be allowed to take control over their own destiny and that provided me with the strength to continue in the face of criticism and possible lack of success in terms of my own culture. To do otherwise would have compromised my own integrity and made it hard to live with myself.

I learned of the difficulty in coming into projects without being in on the beginning, and so having to work with agendas and expectations I had not taken part in negotiating. I learned also that there were many 'realities' at work of which I was only dimly aware. This necessitated 'letting go' in a way which I might not have been so willing to do within my own culture.

Most poignantly, I realised how, in the process of wishing to support a marginalised young woman, I had inadvertently placed her in a position of dissonance with her own culture. Fortunately, I believed the outcome was positive for her. I was later to learn more about the role of gender among Maori people. It was not the place of women to speak on behalf of their culture!

Finally, the metaphorical communication to me of the young woman's story was that my role as a pakeha was not to find out more about the Maori culture. That could only happen when they had regained their knowledge and spirituality and could give it to me from a position of strength. I was left with two voices echoing : the Director's 'The Maori have had their day and have blown it'; and the radical Maori Sovereignty group's 'We must regain sovereignty over our land and our culture or else we die'.

Going with the chaos

This third story follows from the last, but three years on in time. It is about 'knowing' yet 'not knowing'. It is about following what I believed was 'right' but at the same time taking risks through participating in events in which I lost my sense of moment to moment purpose, leaving me wondering about the effectiveness of what I was doing. It is about 'hanging in' without knowing what was going to emerge. It is also about discovering that dialogue contains different meanings for the different participants.

I will take some time sketching the background to this story because the wider social context in which it occurred is important to the understanding of my experiences. Over the intervening years since the 'Cross-cultural Hand-book', I had become progressively more involved with the radical Maori groups who were pushing for change within health and welfare services. They were either workers themselves or members of 'watch dog' groups, monitoring and commenting on the institutional racism inherent in services as they saw it. This involvement was sometimes invited, sometimes uninvited. On several occasions I had sought their support for changes I was seeking within services for which I was responsible - to advise on appointments of Maori workers, or to run an institutional racism awareness workshop for the staff.

On other occasions it was uninvited. They would turn up unexpectedly at various sites within the city, as a small group, to challenge a particular incident or decision which they saw as being detrimental to their people. This was not a tightly organised cohesive group, but rather a network with a loose and changing membership organised around a small core of key individuals. On several occasions the services I was a part of received such visits. Sometimes the challenges seemed just to me, at other times not. However, I was beginning to learn how difficult it was to create a space in an organisation for Maori workers and clients when that organisation had been originally conceived and set up on Pakeha principles, assumptions and inter-personal processes.

In parallel with these developments, Jan had been working with the Maori people in her own organisation. At that time she was Director of Nursing Services for a large metropolitan mental health service, comprising a wide range of hospital and community services. She had initiated a process of extensive consultation with Maori people in Auckland which resulted in the formation of a Maori Advisory Group. This group appointed a co-ordinator who, with Jan's facilitation and support, developed a Maori Assessment Unit within the main psychiatric hospital (the one in which I had previously worked).

The role of the unit was to provide a cultural assessment of all Maori patients admitted to the hospital and was intended to complement the existing service provided. In addition to the co-ordinator, it was staffed by several Maori nurses from elsewhere in the hospital together with non-professional Maori people from the community. Their assessment attempted to understand presenting mental health problems in the context of their own culture, language, extended family and tribal structures and relationships, and spirituality.

I got to know the staff in the Maori unit through participating in the consultation process which led up to its inception, and through continued informal contact after it opened. There were many teething troubles as the unit and the hospital attempted to find a way of coupling together. The difficulties were not only due to culture but also due to a closed institution being challenged to accommodate to the informal practices of groups of people from the surrounding community. For example, hospital routines did not meet the needs of visiting families who

came from far away and needed to be provided with accommodation over several days so that they could participate in the assessment.

There were many cycles of reciprocal challenges, accommodation and adaptation, followed by further friction and challenge, and so on. I dropped in informally whenever I could to give moral support and to also support pakeha professional colleagues who had perhaps tried to find ways of interacting with the unit and had been stung by the 'straight talking' they had received. I had been on the receiving end myself and knew they needed support as well as challenge. I also knew that Jan was standing in the middle of this, trying to support the unit and at the same time trying to support her organisation in managing the change. A brief visit to the unit to say 'hello' sometimes extended to several hours when the staff would ask me to stay and eat with them, or take part in discussions with patients and families with whom they were working. Although I felt I had much to learn from them I realised they were also interested in learning from me.

The vital part of this story came with an invitation from the Maori people to work formally with them. It came at a time of crisis. Jan and senior colleagues had been working over the last year to close and de-commission a special forensic hospital nearby which housed psychiatric patients who had come from the prisons. By this time, all of these forensic patients had been carefully assessed and re-located in various other hospitals or mental health settings according to their needs and according to the varying degrees of risk they posed to themselves and the public. All that remained was a group of about twelve men who required a special environment in which they could develop more appropriate social and living skills in order to survive outside a less secure environment. They were all detained under special sections of the mental health act for people who had committed crimes but were also thought to have mental illnesses or mental handicap contributing to some presumed diminishing of personal responsibility. Within the setting of the old forensic service these men had demonstrated disruptive, violent and sometimes bizarre behaviour and were seen as very difficult to work with and manage. A significant number had committed sexual crimes and one had committed murder.

The plan had been to move this group of patients into a purpose-built building on the hospital site. At the last minute, the health service unions went on strike and refused to work with this group. This created a very difficult dilemma for health managers and the Health Authority as the patients could not continue to stay in their original building which was inadequate and due for demolition. At this point, the Maori Unit stepped in. They reasoned that as nearly all the patients were Maori, it should be their responsibility to look after them. This offer was indeed inspired by genuine caring and concern, but it also contained other agendas: extending their influence for Maori psychiatric patients; and moving to large premises and gaining more resources, for example. In turn, the acceptance of this offer by the governing Health Authority also contained a mix of agendas, including the breaking of the strike. There were wider and complex political agendas at play also, connected with closures of hospitals, changing working

conditions, conflict over provision of psychiatric services to prisoners, and so on. This group of men connected with all of these.

At this point I need to introduce something of the character of the Maori co-ordinator as she was central to the service. Titiwhai was a complex person. She was a passionate advocate of her people who would challenge fiercely and unhesitatingly if she felt compromised or blocked in her purpose. She spoke the 'truth' as she saw it if she felt the situation required it, passionately and sometimes recklessly, irrespective of the risk to her reputation. She came from one of the few tribes which allowed women equal speaking rights in their protocol for formal occasions. She assumed this right in all formal settings, independent of which tribe was hosting the event. She was offended by the sexism she saw in much of her culture's practices, but at the same time fought to claim her culture's rightful place in the contemporary world. Equally she was very compassionate with people she saw as vulnerable. She was also supportive and welcoming of anyone she saw as genuinely trying understand her cause. And often she was very vulnerable herself as she contemplated the enormity of what she was trying to achieve. She was well known as a radical and inspired strong reactions either way, from Pakeha and Maori alike. Such reactions mirrored the increasing split in New Zealand society over the Maori sovereignty issue.

For the purposes of my story, what matters is that the patients were moved into the new building and the Maori Unit took responsibility for caring for them. This required two things to happen quickly. Firstly, an increase in Maori staff numbers, and secondly the formation of a small group of Pakeha health professionals to provide support. The first was solved by Titiwhai getting together a group of young men from where ever she could at short notice. They all had inevitably been unemployed, some had been in prison themselves, and all but a few had been alienated to varying degrees from their own culture and language. But in the circumstances at the time, this was the only pool of people Titiwhai could draw from.

The second was solved by Jan and members of the Health Authority Executive negotiating with medical and nursing staff within the hospital who were not part of the unions involved in the strike. A consultant psychiatrist and several senior nurses offered to provide support. The Maori staff were accepting of this offer but wanted a psychologist. None came forward from within the hospital, so they asked me to work with them.

This placed me in a dilemma. I could not see how I could easily do this from my current job. Although by now I was back in the statutory mental health services run by the Health Authority, I was in an entirely different sector. I was acting head of psychology services to a large general hospital (which also contained a psychiatric wing attached to the local university), and to specialist child and adolescent mental health services for the Auckland area. On the other hand I felt that the Maori unit had placed themselves in a very vulnerable position as they could not deal with this very challenging group of patients without professional and moral support. I had been powerfully influenced by the work I had seen them do so far, but there

was a naïveté about their analysis of professional politics in health which rendered them vulnerable to sometimes unnecessary conflict with the 'status quo'. I wanted to work with them to help the venture succeed and allow the fragile beginnings of an alternative mental health service for Maori people to survive and grow.

After rapid but extensive negotiations I arrived at the new unit to work part-time for a six month period. I felt I had gained the support of my psychology colleagues in my own service, together with that of the Executive group of the Health Authority. But others in my service were less understanding and supportive and thought I was "committing professional suicide". One colleague, a doctor, saw me as making a self-interested career move into becoming an expert in "cross-cultural psychiatry". I was unclear about what the future would hold and felt vulnerable about leaving junior psychologist colleagues less supported in their work than I felt happy with. But on balance I felt this was the 'right' thing for me to be doing in relation to the future of health services.

The philosophical basis for the new unit, called the Whare Paia ('House which makes well'), was that of a partnership under the Treaty of Waitangi. This treaty was signed by the Maori over a century ago in the belief that they were signing governance of their land over to Queen Victoria and her government, but retaining sovereignty for themselves. The radical Maori movement wished the treaty to be honoured in the original spirit in which they had signed it. In practice for the Whare Paia, this meant that the day to day care of the patients would be the responsibility of the Maori people within the context of their own cultural beliefs and practices. This care was to be supported by the team of pakeha professionals, who would provide guidance over the need for european nursing care, medical treatments, and psychological interventions. Together we would share the decision-making.

This is how I came to spend the next year immersed in a bewildering kaleidoscope of changing time frames, values and realities. It is hard to know which aspects of this kaleidoscope to present here in writing, but I will attempt to capture the essence of it for my purposes in as brief a way as possible.

Titiwhai assumed a very strong and charismatic leadership with the Maori staff. First and foremost, they refused to see any of the patients as mentally ill. They either had "sickness of the spirit" or alternatively they were "being naughty" The patients were given straight and uncompromising messages: "We will treat you like men, and expect you to behave like men". Violence or aggressive behaviour was also dealt with uncompromisingly: "We will never throw the first punch, but if you hit us we will hit you back". This in fact happened, but what was very interesting to me was how they then dealt with the aftermath. Two or three would sit in close physical contact with the patient, holding him, stroking him, talking to him. This would go on for as long as twenty four hours and he would not be left alone until it was resolved.

Titiwhai pushed toward normalising patients in every aspect of their lives. This meant visits out to local swimming pools; use of the hospital gymnasium and other recreational and leisure facilities; visits home to families; ensuring they were appropriately dressed and groomed; cooking their own meals; and participating in any meeting or gatherings in the unit where a large room was set up as a traditional meeting house and where traditional protocol held sway.

This placed many demands on the young staff, many of whom were as alienated from their own culture as they were from that of the Pakeha. Many faced problems in their own lives which surfaced in their work. They were supported to some extent by a small number of the male elders from the advisory group, but many of these elders were as conspicuous by their absence as the few were by their presence. There were jealousies and tensions within the group, and although they had corporately selected Titiwhai, many of the men believed it should have been a man leading the Whare Paia.

The push for normalisation and for the resources to support this created much conflict and friction with the wider hospital culture. Many hospital staff had previously seen these patients as highly dependent, dangerous and needing institutional care. They were unwilling to accommodate to their change in status. Similarly, giving patients more freedom, even if closely monitored, required a change in their status under the Mental Health Act. To achieve this required the consent of central government Health department officials and so cases had to be made for this by the pakeha professionals.

So, where did we fit in? For myself, I became unsure what role I was playing. I 'mucked in' according to what seemed needed on a day to day basis. Sometimes I washed and shaved several physically disabled patients, played volley ball, accompanied the group on outings, helped with meals. At other times I spent hours with angry pakeha colleagues from the hospital who had felt affronted by the behaviour of Titiwhai and her staff in advocating for the patients. I made myself available to talk through with them and offer perspectives on what the Maori staff were trying to achieve, and where they were 'coming from'. This was not always accepted. At other times I played 'go-between', translating back and forth between the two cultures, explaining each to the other when it seemed possible to achieve conciliation.

However, there were times when the Maori staff would not settle for this and insisted on confrontation. I sat through some meetings with my heart in my mouth, not knowing what would be said or how events would turn out. Their challenges could be incredibly confrontational and sometimes the tension was almost more than I could bear. I was often confused about the meta-communications. Theirs is a culture based on oratory and so verbal interchanges held many complexities which were not immediately apparent to me. Did they mean what they said, or were they just establishing a position, or both? The culture was historically predicated on 'men as warriors' where warfare was highly ritualised and seen as a spiritual activity. Was this what I was seeing played out in those meetings?

Sometimes my values were affronted by the way they would use violence, yet I could not gainsay the results as over a six month period the level of violent and aggressive behaviour from the patients dropped by a truly remarkable level. Power-over or empowerment? I had long discussions about the extent to which I was prepared to support them and where my personal limits lay.

As the Maori staff got to know the patients better, they were more willing to hear the views of the pakeha professionals - that some patients could not achieve what they were asking of them because of neurological, educational, intellectual and mental illness factors. "Yes", we agreed, "many can be seen as naughty, but some are also disabled by other factors".

As we got to know each other better, I heard of some of the pain in the lives of the young staff and how the work was stressing them. Arthur was Titiwhai's son and took over leadership with the young men. He was many people - a proud orator, a warrior, and a healer. Yet he was a very wounded young man too and there were many stories hinted at but untold about past shames in his family and tribe. His marriage was under stress as he spent days and nights on end in the unit making it work. He started drinking and became violent to his wife. I felt helpless as I watched this and made myself available to him whenever we were there together. Sometimes we would talk directly about himself and his problems. Sometimes we would share life stories, but most often we would talk about problems to do with the work at hand. I would offer my perspectives from a pakeha point of view. I felt very close to him yet very distant.

There were times when I stayed for several days and nights on end to relieve the staff or to fill in when someone did not turn up for work. I became disoriented in moving between this world and that of my own professional world, trying to keep up my commitment to one or two days per week in my original role in the other service. I lost track of time as the familiar markers were no longer present.

The spiritual work was done by the visiting elders and Titiwhai, and often patients would be taken back to their tribal land to resolve issues arising out of transgressions of the 'tapu' or the sacred. This work was not visible to us as pakeha, but we would hear of the outcomes and learn of very harrowing tales which had never been, or could never be, resolved because of irreparable changes in their social and cultural fabric. It was clear that sacred knowledge was now a precious resource held by the few and not to be given to the pakeha. This was their work, not ours.

The making of decisions became problematic for me. I could not make out how decisions were arrived at. On one occasion I became angry because it appeared a decision had been made on an issue about which I felt strongly. I did not feel I had been in on the decision and said as much. The reply came back: "But David, you have. We have listened to everything you have said and taken it into account" I then reflected on that. It was true, the issue had been around for a while, it had been aired in meetings and people had given their views. It was true,

I could recognise my viewpoint implicit in the decision. But I could not find out how a decision had been arrived at. No one could offer an explanation at the time. I learned gradually that it seemed to be an intuitive and implicit process. Sometimes it appeared that a decision had been made, then at a later point it appeared as if it had not.

There was increasing interest from the wider world in what was happening in the Whare Paia, not all kindly or well meant. There were many critics from both races who made much of any incident which could be interpreted as evidence of mistakes or poor practice. As time went on, the Maori staff relied increasingly on the small group of pakeha supporters to provide a buffer against pakeha challenges to the unit. This was not always possible.

The more I became involved, the more admiring I became about what they had achieved, and the more appalled I was at the shaky foundations on which they stood as I learned of how divided they were against themselves. I became both more connected to them and at the same time more alienated, as I recognised ways in which our cultures were so fundamentally different. I simultaneously became more alienated from my own culture while at the same time recognising the need to connect more with it at a fundamental level. I did not know how to resolve the paradox except to leave. I had done as much as I could and they needed to learn to fly themselves. Jan had been a fellow traveller but in a more public and vulnerable way as a manager in the organisation trying to meet the needs of both cultures. We both needed to leave

Lessons taken from this experience.

For much of the time in the Whare Paia, I could not account for what I was doing as a Psychologist. I was not using my professional skills in the way I had been used to doing, within the formal structure of therapy sessions, teaching, supervision, service planning, administration and so on. There were many times I wondered if I was being useful at all. I just seemed to 'be around' and 'spend time with' people. Occasionally I would use formal skills, but not often. Yet I knew that they valued having me there, even though at times it felt it was only as a road-block against my own culture or as an extra pair of hands.

So I was taken by surprise when on leaving they told me of the things I had done for them that I had not been aware of. One of Arthur's comments stayed with me. "You taught me a lot about how groups worked and that helped me understand what was happening." I had not been aware in any way of transmitting this to Arthur. We had never discussed groups or group dynamics and this had not been a conscious intention of mine.

I had no language to describe to pakeha professional outside the small group of us in the Whare Paia what I was doing there as a Psychologist. Even within the group, we did not develop a common language. We were all there for different reasons with different values about what was happening. I could only account for what I was doing in terms of social justice and some deep personal connection. I felt isolated and out on a limb. I had moved away from

my professional base and it would have been very difficult to return back to it in the form of my existing job. All I knew was that I needed distance and time in order to make sense.

This is a very difficult story for me to tell, to do it justice and yet not let it crowd this research account. Eight years on I can still feel strong emotions which have no name but feel like grief, love, pain, welling up as I write. Jan and I left New Zealand immediately to come to England. We left for many reasons and it had always been something we planned to do. The particular timing was influenced by our exhaustion and by a strong feeling that the Whare Paia had made a start and now needed to see if it could survive on its merits. It is still functioning.

Summary.

In some fundamental ways these stories informed the research. For me they demonstrated the increasing importance I placed on the social context in which I worked and the questions this raised about creating conditions for renewal and change. They also represented an increasing isolation and movement away from my professional roots as a Clinical Psychologist and my own cultural base, leading to me feeling out on a limb. They contained the seeds of seeking a place to belong; to stay around for a while and see things through over a longer time; to see if there was a more comfortable relationship possible with Psychology; to account for what it is I do and see if there is a language for it; and to find room for the personal.

The stories also contain the seeds of what I was to confront later in the research. In the first two stories there are issues about my coming into situations and wishing to change practices when the socially shared 'frames' governing the meanings of events have already been established. In the first story the competing frames are professional ones, in the second they are more broadly cultural. There are dilemmas about the degree to which change is possible without either introducing new frames for negotiating meaning at the outset, or alternatively accepting the initial frames and working to introduce or create new ones over the course of time. Within the second and third stories there are dilemmas about accepting the different world views of others and seeking to work within them, but needing to 'let go' and cope with the consequences. The challenge then becomes one of staying within one's own sense of what is ethical or 'authentic'.

Associated with the issue of 'meaning frames' or 'world view s' (either professional or cultural) are the issues of knowledge and power and how these are both exercised in and structured by the relationships and social practices in which individuals participate. These issues arise throughout the research and my dealing, or not dealing, with them becomes one of the narrative threads throughout the remainder of this research text.

Returning to my account of the journey, I needed to explore the research field further and gain some ideas about research methodology which would carry such questions and issues and

enable me to find a starting point. In the next chapter I will take some time outlining the ideas which most appealed about theory and methodology and which came from my reading and from seminars and discussion at Bath in those early days.

4. ENGAGING WITH NEW THEORY AND METHODOLOGY.

Introduction.

The next step for me in entering the research field was to engage with the literature through reading and discussions with fellow researchers at Bath. To continue the journeying sense of the research I will present those ideas which initially suggested themselves to me as being relevant in searching for a way to begin. This will be a 'first look', or a presentation of what appeared in 'bold print' to me at that time. However, as the inquiry process unfolded and my appreciations of what I was about changed, so too did my appreciations about the theory and methodology. I call this my 'second look' or 'the fine print' appreciation which I will return to later in the journey. But first, the 'bold print'.

From what little I knew about qualitative research methodology, Action Research in its broad sense seemed to fit best what I hoped to achieve. My original psychology training was steeped in the quantitative and quasi or applied experimental tradition. The great bulk of research in the clinical field was rooted in this tradition, and even research in the family therapy literature which was not of the individual case study type leaned on this tradition implicitly. I felt ill equipped and I was to find that there still existed a strong 'mainstream psychologist' part of me which required a methodology which was robust, valid and would provide structure to what felt to be a complex mixture of ideas which refused to cohere together into one clear question which could be put to the test. It took some time for this influence to become fully apparent. The first concept in my new reading which helped give structure to my confusion was that of the research cycle.

Research as a cyclical process.

The concept of 'cycling' is more or less present in many models of experiential inquiry, particularly in the forms of action research in which the researcher/s move between action and reflection, or between paying attention to differing aspects of experience. Rowan's (1981) model of the research cycle helped most in bridging my movement away from traditional research models into the more qualitative action forms I was seeking. He intended it to be such a bridge for those making the same transition.

Rowan outlines a dialectical paradigm for research, locating it in the context of day to day life as a dialectic engagement with the world and as a more or less continuous process of inquiry. The researcher and research move through a cycle of stages or phases, moving from one to the next at the point the researcher/s transcend the contradiction of 'too much versus too little' of the activity each requires.

The usual starting point is the *Being* stage, where the researcher is resting in day to day experience but is faced with a problem or inadequacy in practice which gives rise to dissatisfaction. This calls for new thinking.

The *Thinking* stage is an essentially inward movement, a creative process of entertaining new ideas from various sources. It is also a processing movement, adding and combining new information into unfamiliar relationships and comparing against some form of template, asking 'will this do, will it be acceptable?' The nature of the template is dependent on the level of consciousness available. The contradiction between needing more information and having too much information needs to be transcended before moving on.

At a certain point the researcher abandons this stage, aware that thinking is not enough and feeling that there is too much information already. A decision is needed as to what to aim for. An action plan is required, one which may involve daring or risk-taking, some breaking of the bounds. A *Project* is needed which involves others, an essentially outward movement. This involves a degree of assertion ("...or even aggressiveness..."p99), planning and decision making which will create an act of bridging distances , to another person, field or theory. When the researcher has transcended the contradiction of 'plans should be adequate versus no plan can be perfect' then the next stage can be entered.

At this point, action is required. In action the researcher is fully present, here and now, and needs to be ready to improvise if required and to be fully engaged with others. *Encounter* is a stage for testing, for experiment, for comparison in which the researcher needs to face the possibility of both confirmation and disconfirmation. Rowan argues that disconfirmation can provide the more valuable learning. Encounter is a place for involvement, commitment and spontaneity. It is a stage of height and depth, of rhythmic movement inward and outward.

The researcher moves on to the next stage upon feeling 'This is not enough, I must withdraw and find out what it means.' Here the researcher contemplates what the experiences so far have meant for those involved, what are the different ways of seeing them. *Making Sense* involves both contemplation and analysis, turning experience into meaning and knowledge. The contradiction here, according to this model, is between reducing the data to understandable simplicity, versus expanding the connections within the data until they say everything.

From there the process moves to an outward one of *Communication*, telling people what it means and what those involved have been through. This can be done individually or collectively through publications, seminars, lectures and so on. At this stage the researcher has digested what the research has meant and has made it part of a "new accommodation to reality"(p100). [I reflected at a later stage that this latter phrase could be replaced by 'an accommodation to new realities' from within an inter subjectivist or systemic epistemology]. The contradiction here is between the need to get the data more finally processed and accurately expressed versus the awareness of the impossibility of communicating to anyone outside the experience.

At a certain point the researcher returns to daily practise but now on a higher level of awareness, incorporating the new knowledge. This is a return to *Being*, described by the

dimension of height and depth, resting content in being a three dimensional person. The contradiction here is between acceptance of things as they are versus a dissatisfaction which may propel the researcher around yet further cycles.

Rowan notes that the sequence can start anywhere and warns that some individuals may get "hooked" on certain stages without moving on.

My attention was drawn to the intellectual model of a cyclical process, with clearly defined stages, which seemed as though it would provide a link between the research process as I had known it in more traditional terms and the more experientially based action research paradigm I was looking for. I felt that the descriptions of the early stages of this model, of *Being* and *Thinking*, captured my own experience at that time and so located me even then as being in the territory of research, with a sense of how it might develop from here. However, the 'fine print' describing and affirming the phenomenology of going through the whole research experience eluded me until much later. In looking back, I "got hooked", in Rowans terms, on the *Project* phase, looking for the perfect plans when in fact there were multiple possibilities for inquiry already occurring in my practice. I will make this more apparent in subsequent chapters about beginning the inquiry process.

Philosophical underpinnings to 'New Paradigm' approaches.

Another bridge into the research was provided by Lincoln and Guba (1985) who addressed the philosophical underpinnings of the 'New Paradigm' methodologies and articulated clearly the inadequacies of the traditional Positivist or 'Old Paradigm' as a basis for a human science. I found that what had been intuitively felt or only partially perceived by me in the past was now articulated more clearly, validating and legitimising in a wider academic and practice arena what had previously been partly private and shared only by a seemingly small community. Furthermore, it became clearer to me as I read that within the Family Systems umbrella, the epistemological shifts behind the practice models had been only partially articulated, and were more implicit in practice than explicit in outright theorising in the field.

While it felt intuitively right to me to be using qualitative methods, my reading of these authors provided a sounder theoretical and analytical base and satisfied that part of me which liked to have an intellectual appreciation of what I am doing. While my training and reading in Family Systems therapy exposed me to a new epistemology, it had not placed it in a wider context of a paradigm shift which was occurring across many areas of science. I imagined that I would have a critical audience of colleagues who might either challenge my choice of research methodology or who would have questions about the intellectual rigour of such an approach. This had certainly been my experience in relation to family therapy as a 'treatment' approach or way of intervening in mental health and mental illness problems over the past decade. I anticipated a similar challenge with regard to research.

Quantitative methodology and the supposed precision it offers occupies a central position in much Psychological research. Once the choice of specific methodology is made it then

organises the activities of those involved, with richness of meaning and applicability taking second place. At this stage, I felt that my reading could also provide a language for me to help bridge the gap for those immediate work colleagues who might want to join with me in a research venture, and who might need support at this level of 'knowing' in making the commitment to doing things differently.

Lincoln and Guba (1985) use the term Naturalistic Inquiry to cover research endeavours in the new paradigm and they offered me an introduction into some of the philosophical assumptions which lay behind both the old and the new paradigms. Historically philosophers concerned with knowledge and knowing have asked three fundamental and interrelated questions:

- *The ontological* - what is there that can be known?
- *The epistemological* - what is the relationship between the knower and the known ?
- *The methodological* - how can one go about finding out?

Positivism as the philosophical basis for traditional science.

Using the above three questions as a philosophical framework, Guba and Lincoln (1990) summarise the basic belief system of conventional positivistic science as follows:

- *Ontology:* Realist. There is a single external reality 'out there', separate from the observer, which is driven by immutable laws and mechanisms. Our knowledge of this is summarised in the form of time- and context-free generalisations, some of which take the form of cause and effect laws.
- *Epistemology:* Dualist/objectivist. It is both possible and essential for the observer to adopt a distant, non-interactive posture that facilitates 'putting questions directly to nature and getting nature's answers directly back'. Values, whether those of the inquirer or of anyone else, are automatically excluded as exerting influence on outcomes.
- *Methodology:* Experimental/manipulative. Questions and/or hypotheses are stated in advance in propositional form and subject to empirical testing under carefully controlled conditions to prevent bias or confounding. As a basis of a science for people, this denies their self-determining nature and renders them subordinate to the interests of the inquirer or researcher.

They argue that these underlying assumptions are increasingly difficult to maintain in that they deny the role of human judgement and experience, giving "data" a voice over that of those involved as subjects in research or inquiry. They cite what they term "disabling characteristics" of this paradigm as being: its absolutist nature (we are all subservient to only one truth): its objectivist character (in being determined by 'natural laws", humans are reduced to the status of objects); its disempowering character (alternative views are shunted aside, thus maintaining the status quo); and its unethical character (the manipulative nature of the methodology

denies the rights of individuals to choose their own fate). Thus prediction and control are seen as the goals for conventional science.

Guba and Lincoln (1990) lay out the philosophical underpinnings of newer and alternative paradigms which recognise the shortcomings of positivism and seek to amend them in some way. They are clustered together under three broad headings: post-positivism; critical theory; and constructivism. They see the first as prone to the same dangers inherent in positivism, and the latter two as more radical departures. They declare themselves adherents to constructivism.

Post Positivism.

This heterogeneous category was particularly interesting for me because it described what I had come to recognise as the difficulties with which much contemporary and mainstream applied psychology research is struggling. The features of this category were immediately recognisable to me also as characterising the personal struggle I had had over the past few years in looking for a way to do research which honoured how I attempted to practise. Within this category, researchers recognise the methodological short-comings of positivism and attempt to adapt them without recognising the ontological and epistemological contradictions contained therein.

From within this broad category, positivism is recognised by critics as containing a series of imbalances which must be redressed to make the paradigm serviceable again. Guba and Lincoln see these imbalances as occurring between a number of polarities and see 'post-positivists' as failing to transcend these polarities, instead remaining within them and seeking to redress imbalances by merely moving away from one pole towards the other. In this way the authors see the advocates of post-positivism remaining trapped within the conventional positivist world view or paradigm. The following are the polarities which the two authors see 'post-positivists' as remaining caught within.

- *Rigour and Relevance:* Laboratory studies provide rigour through the supposed experimental control over events but severely limit generalisation and hence relevance. The redress is to move out of the laboratory into natural settings.
- *Objectivity and Subjectivity:* The impossibility of a detached stance is acknowledged and the redress is to find some position between the two by adopting qualitative measures of objectivity.
- *Precision and Richness*: The redress is to include more qualitative methods such as ethnographic or case-study methods.
- *Elegance and Applicability:* Broad theories aid generalisation but have little 'fit' at local level. The redress is to adopt a 'grounded theory' approach so that the theory is a product of the inquiry and fits local circumstances.

- *Discovery and Verification:* The process by which a priori theories (the starting point for conventional research) emerge is traditionally left out of consideration as being part of the scientific enterprise. The redress is to conceptualise a continuum of inquiry, from discovery (of theory) to verification/falsification (of hypotheses arising from a priori theory)

While Guba and Lincoln see these accommodations as laudable, their criticism of post-positivism is that it leaves untouched the paradigm level of discourse and its assumption of an objective, foundational reality. Because of this they view this approach as rendering researchers vulnerable to the same dangers inherent in positivism, namely the practice of an unethical and disempowering form of human science.

Critical Theory.

Guba and Lincoln include in this category a wide range of research approaches which they see as being linked together by an acceptance of the role which values play in any field of endeavour. Thus inquiry actively seeks to articulate the values at work and the influence they have on the findings and interpretations. Thus research is as much a political act as any other. Nature cannot be seen as it 'really is' but only through some value window. While Guba and Lincoln allow that this approach makes an epistemological shift to acknowledging the interconnectedness between the knower and the known, they challenge it as not having made the ontological shift away from an implicit acceptance of, or belief in, one objective reality.

This is inferred through language used by critical theorists such as use of the phrase "false consciousness". The goal of much critical theory is to raise consciousness of the participants about the forms of oppression under which they live in order to then act and transform the real world. Thus methodology is characterised as dialogic and transformative, rallying people around a new point of view in order that they can transform their situation.

Critical Theory is summarised as:

- *Ontology:* Realist (albeit critical realist)
- *Epistemology*: Monist/Subjectivist
- *Methodology*: Dialogic/Transformative

Constructivism.

Guba and Lincoln see sufficient risks within Critical Theory, in their view, that they discard it for Constructivism. In particular they see an uncomfortable closeness between Critical Theory's goal of transforming the world on the one hand, and Positivism's goal of predicting and controlling the world on the other. They also see it as failing to take sufficiently into account the theory-ladenness of fact, that the selection of one 'fact' over another presupposes a particular theoretical framework, and the ultimate failure of inquiry to establish unequivocally a given explanation or theory as ultimately true.

They argue for an ontological position of accepting no one 'reality out there', but rather an acceptance of multiple interpretations of any given event, with inquiry having the major task of working toward some consensus among the holders of different constructions. In other words, knowledge is a human construction, never certified as absolutely or ultimately true, but problematic and ever changing. This is the central challenge which constructivism offers to positivism. The underlying set of interrelated beliefs are summarised as follows:

- *Ontology*: Relativist. Realities exist in the form of multiple mental constructions, socially and experientially based, local and specific, and dependent on their form and content on the persons who hold them.
- *Epistemology*: Monist/Subjectivist. Inquirer and inquired-into are fused into a single fused (monist) entity. Findings are literally the creation of the process of interaction between the two.
- *Methodology*: Hermeneutic/dialectic. Individual human constructions are elicited and refined hermeneutically, and compared and contrasted dialectically, with the aim of generating one (or a few) constructions on which there is substantial consensus.

Guba and Lincoln promote this as the preferred alternative to positivism because it puts humans at the centre of the inquiry process, is educational to all participants, it "tilts towards" ethical inquirer behaviour, makes scientists 'humans too', and is both empowering and emancipatory. It sees social change as resulting from changed constructions. By virtue of their participation, they argue, individuals are enfranchised to assist in determining what to do and how to do it.

I found I could map the ontological and epistemological set of beliefs of constructivism onto various personal experiences. The epistemological position was similar to that implicit in various family therapy models. My experiences in working with Maori people had shown me glimpses of very different 'realities', as had various personal transcendental experiences. However, the methodological position left me unclear about how as a researcher I could actually go about setting up an inquiry process whereby such an "emancipatory" participation became possible.

I found myself hovering somewhere between critical theory and its preference for transformative action in the "real world", and constructivism and its preference for transformation in the mind of constructors, human beings. I resolved this at that stage by assuming that if constructivism allows for multiple realities then it should allow the positions it criticises as being potentially useful at certain times, as possibilities for seeing or interacting with the world at any one time. In other words, perhaps there are times when it is useful, transformative and so on to act 'as if' there were a certain 'truth' whether it be a truth about a political reality or about a particular objectivity. I recalled Bateson's (1979) concept of 'wisdom' as having an awareness of how all the elements in a system were connected. There seemed

a resonance here in that the challenge posed by constructivism was to know when one was acting 'as if' something was 'true'. It seemed wise also to bear in mind critical theorists critique of constructivism as running the risk of equally valuing all constructions and hence paralysing political motivation of groups who are socially, politically and economically disenfranchised. (e.g. Burman, 1990)

Nonetheless, in their earlier work, Lincoln and Guba (1985) proposed some implications for conducting inquiry which appealed as a more general set of guidelines at a conceptual level. Again, these seemed as if they would be useful to share with others entering any inquiry with me to help 'make the leap'.

Implications for New Paradigm Inquiry

- Research is carried out in the natural setting or context of the entity to be researched for the fullest understanding to be gained. This stems from an assumption that realities are wholes which cannot be understood in isolation from their contexts.
- People are the primary data gathering instruments.
- Tacit or intuitive knowledge is legitimised in addition to propositional (theoretical/analytical) knowledge. This allows for subtle nuances, different realities, and differing value bases to be appreciated.
- Qualitative methods are used in preference to quantitative, although not exclusively so. They are more sensitive to mutually shaping influences and value patterns.
- Purposive sampling or theoretical sampling is elected over representative or random sampling. This allows for a greater range of data to be exposed and also maximises the ability to develop grounded theory which takes account of local conditions.
- Inductive data analysis and interpretation allows investigator-respondent interaction to be made more explicit and accountable. Also this process is more likely to describe the setting and context and therefore make transferability to other settings easier. Conclusions are drawn in terms of the particulars of the individual case and any conclusions about broader applications are tentative.
- The guiding substantive theory emerges from or is grounded in the data because: no a priori theory could possibly encompass the multiple realities or frameworks that are likely to be encountered; the researcher wishes to approach transactions as openly and neutrally as possible; and a priori theory may not provide an idiographic fit to the situation encountered.
- The research design and boundaries of the inquiry are allowed to emerge in the interaction with other participants because insufficient can be known in advance about what will be encountered.

- Meanings and interpretations from the data are negotiated with those involved.
- A case study reporting mode is preferred over scientific or technical report mode, allowing for a richer and more authentic description which in turn allows for easier transferability to other settings.
- Special criteria for validity or trustworthiness are required because conventional criteria do not fit well with the assumptions of the new paradigm.

These felt as though they would be a solid set of principles to put into my researcher's tool kit, ones which satisfied my need to have theoretical frameworks which helped me make sense of and account for what 'I do', and ones which I anticipated might be helpful in supporting colleagues into joining me in a research venture into teamwork and practice. However, I was left with two related questions. If the emphasis in new paradigm inquiry is on people being the primary data gathering instruments, requiring multiple forms of knowledge, then how do individuals go about 'calibrating' the instrument and utilise tacit and intuitive knowledge. Secondly, how do I as a researcher go about setting up inquiry which is both empowering and emancipatory.

Knowledge - for action and in action.

The two approaches of Cooperative Inquiry and Collaborative Inquiry seemed to offer some answers to my two questions. Both take the epistemological approach that knowledge is gained in and for action, and that the primary purpose of inquiry is to produce well-informed action. Both offer explicit ways of developing collaborative relationships among those involved in inquiry. However, they differ in the ways data is collected and analysed

Cooperative Inquiry

In sketching out a philosophical basis for a new paradigm of inquiry, Heron (1981) challenges orthodox research methods as being inadequate for a science of persons on the grounds that they undermine the self-determination of their 'subjects'. He argues that what distinguishes the human person is the ability to choose how they will act, and the capacity to give meaning to their experiences and to their actions. It is this "self -directing ability" which he argues is undermined in conventional research, where subjects are 'other-directed' by the researcher and are systematically excluded from all choice about the subject matter of the research, the appropriate inquiry method, the creative thinking that goes into making sense of the data, and the communication of the results. He proposes that it is possible to conceive of an approach where all participants are self-directed. He use the term Co-operative Inquiry to describe an approach where the distinction between 'researcher' and 'subject' is dissolved to the extent that in its fullest form both are fully involved in the action and experience to be researched. This approach draws upon differing forms of knowledge and it is these I wish to highlight here.

He argues that empirical research on persons involves a subtle, developing interdependence between three forms of knowing - propositional knowledge, practical knowledge and experiential knowledge.

- *Experiential* knowledge is knowing an entity (person, thing, place, process, and so on) in sustained face to face encounter and interaction. It is often tacit or intuitive and comes from a perception of spatio-temporal wholes or gestalts which always transcends any set of propositions about the entity in question. It tells us of the interplay between the posited world and the presented world. It comes from sustained perception and interaction, construing and doing, with some degree of commitment to get to know the phenomena in question. It is knowledge through acquaintance.

- *Propositional* knowledge is that from the realm of theory, analytical concepts and propositions (which in traditional science have come to assume the status of facts or truth). It is expressed in the form of statements and tells us of the researched world. Traditional research draws heavily on this form and it is the main form of knowledge accepted in our society. It comprises laws, theories, propositions, concepts and statements about facts. It may be latent and partially inform our perception the world. Research findings are typically expressed in this domain. It is 'knowing about'

- *Practical* knowledge is a set of skills, 'how to' proficiency or knack, whether physical or mental. It tells us of the world of action and in research activity is a set of interrelated skills which cannot be reduced to a set of written instructions. This form takes primacy in qualitative/experiential/action research.

At a later date, Heron (1992) goes on to extensively develop this extended epistemology and elaborates a fourth domain of 'presentational' knowledge.

- *Presentational knowledge* occurs through perceptual imagery whereby we become aware of metaphor, analogy, and symbol. Art and music are particular representations of this form of knowledge. Awareness of pattern connecting the elements of our awareness is the key outcome within this domain of knowledge and it forms a bridge between experiential and propositional forms.

In this later work Heron describes what he calls an 'up hierarchy', moving from experiential up through presentational and propositional to practical, each grounded in the preceding one. Although each form or domain will predominate at different stages of experiential research, practical knowledge takes primacy.

At the outset of my research journey, Heron's conceptualising of these forms of knowledge opened up the personal processes I had been partly aware of in practice, but for which I had no language or name. It legitimated intuitive and tacit knowledge, and in the naming of different forms allowed more explicit noticing and developing of them. It had been a regular experience for me in practice over the years that in difficult situations, where there was a mass

of seemingly contradictory information, I would tend to redouble my efforts at making sense in propositional terms, being wary of trusting intuitive and tacit knowledge. Heron had provided me with a beginning language which legitimised further exploration and ownership of these domains of 'knowing'. As these domains are described in propositional form, they also provided a language for communicating more fully with others who might become involved in the research.

Reason (1988) develops Cooperative Inquiry considerably further. He defines it as:

> "...a way of doing research in which all those involved contribute both to the creative thinking that goes into the enterprise - deciding what is to be looked at , the methods of inquiry, and making sense of what is found out - and *also* contribute to the action which is the subject of the research. Thus in its fullest form the distinction between researcher and subject disappears, and all who participate are both co-researchers and co-subjects. Cooperative Inquiry is therefore also a form of education, personal development and social action."(p.1)

Clearly, Cooperative Inquiry is not always possible in its fullest form, and within the methodology there are a range of possibilities in which participants can be involved in an authentically collaborative way at different stages in the inquiry process. Reason argues that the minimum criteria for a research strategy to claim the term Cooperative Inquiry are: that the involvement of all participants be openly negotiated; that all participants be involved in the creative thinking that is part of the research; and that relationships should aim to be genuinely collaborative.

This was appealing to me at a number of levels. Firstly, it directly addressed my discomfort about my first and only formal experience of research as excluding the participants from all but a very small part of the process, leaving them with very little gains from the endeavour. Secondly, it addressed my belief that effective mental health work involved change, at both personal and social levels. Thirdly, it laid out a clear methodology which gave me a framework as a beginning researcher for guiding the process and also for engaging colleagues whom I anticipated would also welcome this as a step into a new way of researching. It also had criteria for validity to answer questions I and colleagues would have on this topic

Fourthly, Cooperative Inquiry introduced me to the concept of authentic collaboration as a principle vehicle for conducting research. It highlighted the importance of negotiating the genuine involvement of participants at each stage according to interests, commitment and availability. The model seeks to create conditions in which authenticity of participation can be made explicit and attainable. This fitted with some of the values I held about multi-disciplinary teamwork and so as a methodology it had a degree of congruence with the area I wished to research and also with the possibility for developing professional practice.

Cooperative Inquiry involves the participants in recurring cycles of action and reflection which move through a number of stages. This appealed to me as a map for venturing into unfamiliar territory as a researcher, linking theory with practice. As a preliminary step the initiating researcher meets with interested participants to inform them about the methodology, its underlying principles and to outline the area of interest. From there the following cycles unfold.

- The researcher facilitates the group in discussing and agreeing on the exact focus of the research; what ideas and theories they bring to the inquiry; what kind of research action they will undertake to explore these ideas; how to observe, record, measure and otherwise gather their experience for further reflection. This stage is primarily in the realm of propositional or theoretical knowledge.

- Participants then take these decisions about research action into their professional work. They engage in what ever behaviour has been agreed, note the outcomes and record their discoveries. This may involve self observation, reciprocal observation of other members of the inquiry group or other agreed upon methods of recording experience. This stage is primarily in the realm of practical or 'how to' knowledge, involving skills and abilities.

- There follows a 'deepening' of the previous stage, where participants as far as possible bracket off any preconceptions or ideas they started with in the first stage and become fully immersed in their practice. They become deeply engaged with the subject of the inquiry, opening themselves to new experience and paying close attention to what is happening. This stage is primarily in the realm of experiential knowledge, or knowledge by encounter which is intuitive and holistic.

- Participants now return to reflect on their experience and make sense of it. This will involve revising and developing ideas and models they started with. This reflection will involve all forms of knowing. When this stage has been completed participants can then consider how to engage in further cycles of inquiry, systematically honing and refining ideas, practice and experience.

At the completion of an agreed upon number of cycles, the participants will have reached the point where they have finished 'making sense' and will wish to communicate their findings.

There were other distinguishing features relating to the practice of Cooperative Inquiry which caught my eye as connecting with the knowledge and interests I brought with me.

- *Participatory and holistic knowing:* We are each part of any system we are observing and hence participate in how events are framed or constructed. Holism is concerned with understanding the systemic whole, rather than studying the parts in isolation from each other.

- *Critical Subjectivity*: Developing a quality of awareness which seeks to bridge and integrate both subjectivity and objectivity, honouring individual experience and including this as part of the inquiry process. Such a quality of awareness would embrace all ways of knowing as outlined by Heron (1981).

- *Knowledge in Action*: Knowledge is formed in and for action, rather than in and for reflection.

I imagined that Cooperative Inquiry would provide a process whereby members of different disciplines could work with each other in inquiring into their own and each other's practice and explore the possibilities for teamwork. I saw this method as capable of carrying some of the questions I had at the outset of the research about teams, team working and my role within. The inquiry process also offered potential for making explicit some of the professional world views which inform practice and which I saw as critical to understanding and resolving some of the dilemmas about multi-disciplinary teamwork - as exemplified in the 'dance' metaphor in the earlier NZ story about my experiences in an acute psychiatric ward. However, these very issues raised questions for me about how to engage colleagues from different disciplines in such an inquiry. So far, in my new work setting, my observations of tensions and differences among members raised my anxiety about how I would be able to facilitate a Cooperative Inquiry group as initiating researcher. This anxiety was to pursue me for some time.

There were also questions for me about the 'making sense' phase of the inquiry process as the method itself does not offer specific means of data analysis (although Reason (1988b) describes a range of methods other researchers had used in this phase). However, at this stage I was more concerned about getting the inquiry under way and assumed that in any Cooperative Inquiry group the decision about the most appropriate means would be made within and by the group.

A final issue for me at this stage in relation to Cooperative Inquiry as a potential methodology was the actual practice of a 'critical subjectivity' and 'knowledge in action'. Although they were conceptually clear enough to me, and grounded in Heron's extended epistemology, the operationalising of them was less clear. I imagined that 'critical subjectivity' might be similar to what was referred to as an 'observer' postion in some psychological therapies, a state of self awareness which the therapist adopted from time to time to monitor personal and interpersonal process. I had some experiential understanding of this but was interested in gaining a more sophisticated understanding of how this could be developed for research purposes. This personal reflexivity was to become a major challenge and point of learning for me as the research proceeded. In the meantime, Torbert's model of Collaborative Inquiry offered a potential framework for developing a more systematic means of achieving a 'critical subjectivity' and it is this to which I now turn.

Collaborative Inquiry.

Torbert (1981) was able to develop much further for me the concept of knowledge in and for action at the individual level of being both a researcher and practitioner. His model of an 'Action Science' which he termed Collaborative Inquiry seemed to me to provide some directions for how individual researchers could carry their research into their practice in the second and third stages of a Cooperative Inquiry.

Torbert starts from the position that scientific knowledge from traditional research is based on unilaterally controlled experimental conditions. This, he points out, is only one particular kind of social context and an "authoritarian" one at that. It fails to take into account that research subjects, students or colleagues and subordinates may have a different viewpoint from the researcher on what is important or at stake. In this context research is implicitly unjust.

Furthermore the knowledge gained from such a venture is a 'disembodied' knowledge which is focused away from the actor toward the external world where it is assumed there are simply facts which are there to be observed independent of the observer. So there are underlying assumptions about the nature of reality which traditional science fails to test in any systematic way.

What the traditional models lack, he argues, are the qualities necessary to help us as actors increase the effectiveness and justice of our actions. Therefore he proposes that what we require is a kind of knowledge that we can apply to our own behaviour in the midst of ongoing events. This needs to be a type of knowledge which helps us inquire more effectively with others about our common purposes, and about how to produce outcomes congruent with such purposes. This knowledge should not be bounded by the immediate events under consideration but should take into account all information as potentially relevant. Torbert considers we should be able to respond justly to challenges or interruptions from events outside our immediate focus and inquire into their relevance for us.

To meet these requirements, Torbert proposes a model called Collaborative Inquiry, based on the assumptions that knowledge is always gained in action and for action, and that research and action are inextricably intertwined in practice. This model is an extension of earlier work done by Argyris (1976) and Argyris and Schön (1974) on leadership in organisations and the links between theory and practice in professional practice. Argyris and Schön showed that individuals seldom developed the necessary quality of attention to test out whether their purposes, strategies and actual behaviours are congruent with one another. They observed that, despite values espoused to the contrary, many individuals in business and professional organisations employed an interpersonal strategy they termed *Mystery-Mastery*. They characterised this strategy as narrow, goal-oriented and manipulative. It has four governing variables.

- Define goals and try to achieve them (participants rarely try to develop with others a mutual definition of purpose, nor do they open themselves to be influenced in their perception of the task at hand).
- Maximise winning and minimise losing (changing goals is seen as a sign of weakness).
- Minimise generating or expressing negative feelings (to do so is seen as ineptness, incompetence or lack of diplomacy - permitting others to do so is seen as a poor strategy).
- Be rational, objective and intellectual, and do not become emotional.

The outcomes of the mystery-mastery strategy are often, ironically, feelings of loss of control over use of time and feelings of being victimised by external pressures. The strategy also engenders competitive relationships and prevents any clarification of purposes or discovery of the extent to which participants can either work cooperatively towards shared purposes, work separately towards different but non-hostile purposes, or resolve conflicts among purposes. The result is often a sense of isolation and mutual mistrust. This strategy prevents participants from publically noting or personally acknowledging incongruities among purposes, strategies, practices and effects, thus preventing any learning from experience. So this strategy tends to lead to individual and organisational patterns which are self-sealing and defensive rather than self-correcting.

It was a strategy I recognised well at individual, team and organisational levels and one which I noted myself sometimes accomodating to, by adopting its tactics when strongly feeling its presence. A strong sense of personal unease highlighted its presence, as it contrasted strongly with my overall strategy in my work setting of 'joining with' and trying to meet people where they 'were at'.

Torbert seeks to take Argyris and Schön's work a step further by proposing an alternative model of practice which he terms an "Action Science" and which aims to develop "genuinely informed" action, increasing our effectiveness as either researchers or practitioners. To act in a genuinely informed manner, the acting system (be it individual or organisation) requires valid knowledge about the its own purposes and about the quality of interplay between itself and the outside world. This requires the cultivation of what Torbert terms an *interpenetrating attention* span which embraces the interplay back and forth between intuitive purposes (using intuitive knowledge), theoretical strategies (theoretical knowledge about options available), behavioural methodologies (behavioural and sensory knowledge) and external effects (empirical knowledge about effects of action on people/the system).

This quality of attention can allow the development of "sensual awareness" and "supple behaviour" which enables the acting system to learn from experience. Valid knowledge can only be developed by an acting system to the extent that it examines incongruities between these four domains of experience. This may then lead to a science of reflection in action, or

'experiments in practice', as the acting system acts to inquire further into possible incongruities between the four territories of experience and seeks to align them more congruently (or live more awarely with the incongruities).

The concept of an interpenetrating attention span stood out to me at that stage as being the most interesting feature of Collaborative Inquiry. As with my reading of other theories and methodologies at the time, many features about conducting Collaborative Inquiry remained as 'fine print', only becoming salient or 'bold print' later on as the research progressed and as I was able to ground them in actual experience.

However, what I was able to read and see as directly relevant to beginning the research were his range of distinguishing features of "experiments in practice". Some of these carry assumptions which are similar to those in Naturalistic Inquiry. Those features of experiments in practice which were most salient for me were ones I saw as most challenging of the role of researcher in the old paradigm and which were most immediately challenging for me personally. I was aware that I had a part of me which liked to 'get it right' and go into situations 'knowing' as opposed to 'not knowing'. These features are as follows.

• Experiments in Practice.

- The structure and variables are not merely pre-defined but rather may change through dialogue between the initiating actor-researcher and others.
- Interruptions are welcomed , symbolising that which is not present within the researcher's awareness at the moment of interruption , inviting a more encompassing awareness of what is at stake.
- Conflict between different paradigms of reality is anticipated and welcomed as an opportunity to test assumptions and explicated as far as possible.
- The interest is as much in knowledge uniquely relevant to the particular time place and people of the experiment as in knowledge that is generalizable (this compares to Lincoln and Guba's concept of 'transferability')
- The ultimate criterion of whether a given action is aesthetically appropriate, politically timely and analytically valid is whether it yields increasingly valid data about the effectiveness of any acting system.
- The media of research are: interpenetrating attention; symbolic, ironic thinking and feeling capable of apprehending the issues at stake; action; collection, analysis and feedback of empirical data.

Collaborative Inquiry is described by Torbert as an experiential process occurring in a more or less distorted and incomplete fashion at any give moment. However, at this stage of my reading and understanding this was somehow in 'fine print'.

Collaborative Inquiry also provided a further bridge from practice into research in that it spoke to my interest in family systems therapy. In this field there are many contradictions between the level of thinking about therapy and the level of practice of therapy. At the level of 'thinking about', the ideas of Gregory Bateson were extremely influential. His analogy of 'mind' as the pattern which connects the elements in our awareness (1979) contained within it challenges to our commonly held conceptions of self. He maintained that 'self' was an artefact of how we chose to punctuate the pattern which connects, and did not have a separate existence in the sense of being a foundational reality independent of the knower. In the process of operationalising his ideas at the level of therapy practice, much got lost in the translation. So the concept of self and the individual remained muted. Yet, implicitly, the use of 'self' by the therapist in the more active forms of therapy was the main influence for change. As a result, there is a lot at the level of 'performance' written in the literature, but little at the level of self as an instrument for collecting data and making sense.

However, this has changed more recently as constructivist and social constructionist ideas (e.g. Gergen, 1985) have infiltrated the field, with the thinking of the therapist being 'part of the field'. There is a return of interest in the individual and the self, but the emphasis is on knowledge for-action rather than in-action. The thinking of the therapist is taken into account in hypothesising about the nature of meaning and relationships before and after sessions, but not in-action. In Heron's terms, the emphasis is on propositional and practical knowledge, not on experiential or presentational. It seemed to me that Torbert may have something to offer in terms of knowledge in-action. This then provided another bridge into the field of research from my base as a practitioner.

These then were the salient features from my reading of the new paradigm research ideas and methodologies at the early stages. There were many intersecting features between Naturalistic Inquiry, Cooperative Inquiry and Collaborative Inquiry, but through reading and discussions at Bath I came to understand at a propositional level that there were distinguishing features, that they asked different questions.

Distinguishing features of the models

Distinctions between the above models became apparent from reading and from discussion with fellow researchers at Bath.

- *Rowan's Cycle of Research* is part of a dialectical paradigm for research which seeks to locate the researcher fully in the phenomenology of the research process, and asks questions about the awareness of the dialectical relationship between the researcher and the phenomena in question (including the self). It seeks to reduce alienation between the knower and the known and to bridge the old paradigm with the new.

- *Naturalistic Inquiry* emphasises knowing about the world and its concepts of validity or 'trustworthiness' come from high quality awareness of epistemological considerations.

- *Cooperative Inquiry* makes assumptions about people as being self-directing and concerns itself with authentic collaboration. Its concepts of validity are embedded in the processes necessary to establish and maintain authentic collaboration, harnessed with the co-researchers/co-subjects personal process or 'quality of knowing' which draws on all of Herons four ways of knowing. Its primary data are those collected through action and then subsequently analysed both individually and collectively.

- *Collaborative Inquiry* has a concern with timely action and its primary source of data is through 'on-line' self awareness in the midst of action, with less of an emphasis on more systematic collection of data and subsequent analysis. Validity comes through seeking congruence between the four territories of experience (purpose, strategy, behaviour and outcome) or living awarely with incongruities.

In following chapters I will describe how I began using these ideas and what I took from them as I made further steps into the research field. At this point I would like to make a narrative comment. Rowan's (1981) conceptualisation of the cyclical nature of inquiry appealed as a more generic description of the research process. Although in retrospect this model clearly includes my early questions and dilemmas as a legitimate part of the inquiry process, and ought to have alerted me to the possibility that I was at that stage 'inquiring', I was unable to see this. In my view at the time, as I had not yet entered the 'project' phase, I had not yet 'begun the research' and so continued to stumble for some time yet. This was not the only occasion in which I was 'standing outside' the process, not including my day to day experiences reflexively within the field of inquiry. There was a contradiction which persisted for some time which went as follows - despite my interest in and practice of systemic therapies, as a researcher I was still unawarely located in the mainstream paradigm as an observer who was not applying theories and models about human experience reflexively to his own experience. Thus for some time I was operating in a frame of 'I have not begun the research yet'.

SECTION TWO OVERVIEW.

In this section I will present the different ways in which I began to explore the implications for research of the different theories and methodologies I had considered to date. As I attempted to find a focus for the research which held the questions I was asking, and as I tested out different methodologies as to their suitability for my purposes and for the setting, I also began the process of capturing experience as I went. As I have already mentioned in Chapter Two in which I describe Narrative Inquiry, I did not have an explicit model for story telling as a methodology at this stage. I was searching for an authentic means of recording and reporting on my experience in the research field and story-telling emerged as a form for doing so, but without reference to the wider research literature. This section reports on these developments.

I started in the form of a reflective diary, augmented with numerous notes and journals in which I recorded observations, reflections and descriptions of events. These ranged from the informal to the formal. Some were cryptic phrases or notes I made to myself in the middle of meetings or conversations, some were jottings in my journal in the middle of the night when a vital idea occurred, and others would be more careful and considered descriptions of a series of events over preceding days

As I needed to start communicating to others about what I was doing, I wrote more carefully crafted accounts, bringing material together to link action, reflection and theory. I discussed these in draft version, with supervisors, fellow researchers in the Bath group, and with family. They were changed according to comments, questions or new understandings, until they authentically represented my experiences at the time and allowed me as a researcher to take meaning from them.

As I mentioned in connection with the New Zealand stories in the previous section, I discovered through this process that the writing up of research experience became a form of inquiry in itself. As I wrote the more crafted accounts, new meanings suggested themselves which then enriched further action and reflection.

This was not the smooth cyclical process implied by this description, rather it was a halting, discontinuous process as I struggled with the boundaries of what should be part of the research process. As I wrote reflective diaries I found that what I intended to be brief notes from the day with a few observations could easily become two and three hour sessions of writing. One reflection would lead to another and yet another, as experiences in the present linked to those from the past. There were times when, because of this, I could not face writing in my diary at the end of a tiring day at work. I did not want to cope with a cascade of reflections which led every which way in time and space.

Furthermore, for some time I felt I was waiting for the 'research proper' to begin and saw my day to day noticing of my practice as being 'merely preparation'. I started with the clear idea

that I would use Cooperative Inquiry, but as that prospect seemed increasingly difficult to achieve I began to stumble. I kept diaries and wrote accounts of this process, in preparation for the time when I could start a research project, preferably using Cooperative Inquiry. But even this noticing of practice and day to day experience was difficult. What to notice, what to capture and write about, what to include, became problematic. I became increasingly vexed by my seeming inability to 'start the research proper' and eventually reached a crisis point. This led to an analysis of gender and the role it played in both the production and resolution of the crisis. Thus 'how to engage in research? ' became the key question for a while and this is also the subject of the chapters in this section.

As I began to produce more crafted written accounts of my experiences, I wanted to capture the complexity of what was happening. I wanted not only to acknowledge the influence of the past, but also to do justice to what was happening in the present. I wanted the reader to have a rich enough sense of the setting and the action that they could then follow how I was construing meaning and making sense of my experiences within that setting. These intentions expressed themselves in a series of questions I posed for myself about writing at the time.

- How can I convey in writing the experiences I bring into the research which influence who I am, how I see things and what is important for me?
- How can I best represent and express the multiplicities of experience I am having as I engage in the research?
- How do I know that what I have written is the best representation of the situation at hand as I see it, that it is 'true' for me?
- How can I write respectfully and responsibly about other people who have been a part of the experiences I am inquiring into?
- How can I convey to the reader that this is authentic and genuinely gained knowledge, so that it will seem 'true' to them?

In thinking about how I might answer these questions, I considered three possible sources. Firstly, I considered that the various criteria for rigour and quality of knowing from the research methodologies could also be a source of criteria for quality writing. In the first chapter in this section, I will consider the criteria which seemed suitable and which informed my writing to varying degrees.

Secondly, the above questions also reflected my own notion of being 'authentic' in life and so they led me to think about the principles which express this. The following are principles of personal authenticity which I tried to keep available to me throughout the research, and which form a second source of criteria for writing.

- Being true to my own values.
- Being open to others in a genuinely inquiring way.
- Noticing my own assumptions at work and being willing to amend them in the light of new knowledge.
- Being prepared, within the limits of the relationship in question, to surface my own framings, purposes and understandings of the phenomena at hand, and to support others in doing likewise.
- Working with others collaboratively while at the same time acknowledging differences according to gender, culture or social role.
- Being respectful of others' epistemology while retaining the right to challenge it.
- Affording others the rights I hold for myself.
- Assuming that others wish to do things as well as possible within the constraints of their own history and current life circumstances.

It is important to note here that I do not always achieve this and can become impatient. I am inclined to 'work too hard' and be 'too helpful' when I see others struggling and this can sometimes be perceived as controlling or 'lecturing'. On other occasions I can be seen as 'too respectful' or 'too patient' and leave people wondering where I stand. There are contradictions in this too, because I tend not to afford rights to myself which I afford others. For example, I tend to assume that if things do not work out as hoped then it is because I have not worked hard enough.

Thirdly, I used my own set of guidelines from the theory and practice of therapy. This comes from a network of assumptions about people and change which has developed in a reflexive relationship with practice over the years. I use it as a navigational aid, to answer questions about 'Am I on the right track with this client? As I began writing, these assumptions emerged more explicitly as informing my accounts of practice around individual clients. In this section I will make explicit some of these guidelines and the way I believe they help answer the questions of authenticity I set myself.

In this thesis I am making much more explicit how these sources informed earlier writing and earlier drafts. The importance of doing so now comes from a recognition that these early research experiences constituted 'inquiry', as did the writing about them. It took some time for this recognition to occur to me.

The chapters in this section will therefore attempt three things:

- To describe early attempts at exploring different methodologies in developing a focus and finding a form for research.

- To consider in more detail the criteria for quality of knowing associated with the different approaches.
- To look at the warrants I took from the various sources to develop a style of writing as authentic representation of research experiences.

5. CRITERIA FOR RIGOUR AND QUALITY OF KNOWING: INFORMING PRACTICE AND THE WRITING ABOUT PRACTICE.

Introduction

Given the 'fine-print/bold-print' analogy I have used to describe my early reading and understanding of the research literature, certain criteria or concepts which embody rigour and quality of 'knowing' suggested themselves more than others as being relevant to me. At this point I sought to move away from the term 'validity' as it all too powerfully evoked earlier frameworks for research in the quantitative and experimental tradition - these were concepts I had been thoroughly taught in my training regarding the practice of psychometric testing.

At this stage I wish to present my growing understanding of issues of quality of knowing and how I saw them as being relevant to early attempts at action inquiry.

I am also making explicit here the concepts from research literature and from my clinical practice which underpinned my early writing. I do not pretend that I used these all in a fully conscious way, rather they occupied foreground and background according to the experiences under consideration and my intentions at the time. I will consider relevant criteria from constructivist and critical theory positions, from Naturalistic Inquiry, Cooperative Inquiry, and Collaborative inquiry. I also consider warrants from recent theorising in the field of systemic family therapy, and from some clinical practice frameworks.

In subsequent chapters in this section, where I write about my exploration of several inquiry approaches, I will comment on my use of these criteria. Again, they pre-date my explicit awareness of and use of a Narrative Inquiry framework. However, looking through these lenses at this stage of my journey, this chapter represents a dialogue with other voices from the literature and a seeking to find a coherent set of quality and rigour criteria for both practice and writing.

The inclusion of this chapter at this point may suggest a linearity of progression in use of and understanding about quality criteria. In practice the reality was more complex as this growing understanding developed reflexively with writing, practice and dialogue with others. I include the chapter here as frame for guiding discussion about 'quality of knowing' issues throughout subsequent chapters. This discussion pre-dates my explicit awareness of Narrative Inquiry as a research methodology, with its accompanying criteria for quality of knowing. However, the warrants for writing which I outline have many features which resonate with it. I will present my selection of warrants in two sections, from theory and from clinical practice.

Warrants from Theory.

Warrants from Constructivist philosophy.

Some of the ideas from a broadly constructivist epistemology have been emerging in the family systems literature over the past decade and have been influencing practice in that field (and I

will refer to these shortly). So, although I had some familiarity with the concepts, it was not until reading Lincoln and Guba's (1985) Naturalistic Inquiry that I became more familiar with the philosophical underpinnings of constructivism and where it stood alongside other philosophical frameworks. Further reading of them (Guba and Lincoln, 1989) provided a more elaborated set of assumptions underpinning inquiry within their broad ranging constructivist paradigm. This provided me a standpoint for 'knowing about things' which guided and warranted my writing about research experiences in storied form, and which started to connect with developments in the family systems field.

As I started the research, I also took up a teaching role in a local introductory course in Family Therapy, and in the process caught up with more recent developments in the field which were influenced by social constructionism. I realised that much of my training and practice had implicitly been informed by critical theory assumptions. Namely, that there were some 'truths' or state of affairs which were likely to be more useful and transformative than others, and I as a professional sought to expand peoples' awareness about this and help them move toward it. Structural Family therapy is an example, based on certain notions of 'healthy family'. Taking such a position can be empowering for both practitioner and client, provided there is some level of conversation which examines the underlying assumptions and checks their degree of 'fit' for the individuals and the setting in question.

So, as I was reading about this for teaching in family therapy through constructivist lens, I was also learning more about it through reading for research. The following are a series of assumptions which Guba and Lincoln make which flow from a constructivist philosophy and which intellectually appealed as grist for the research mill.

- "We cannot stress too strongly the assertion that human knowledge consists of a series of constructions, which, precisely because they are humanly generated, are problematic, that is, indeterminate, unsettled and ambiguous." (p68).

- "Constructions represent the efforts of people to *make sense* out of their situations, out of the state of affairs in which they find themselves. They are *interpretations* based primarily on experience - to "see it with my own eyes" or to "hear it with my own ears" is the best evidence that anyone can muster to demonstrate to him or herself the validity of his or her own constructions" (p70)

- "...constructions are, quite literally, *created realities*. They do not exist outside of the persons who create and hold them: they are not part of some "objective" world that exists apart from their constructors".(p143)

- "Constructions come about through the interaction of a constructor with information, contexts, settings, situations, and other constructors (not all of whom may agree) using a process that is rooted in the previous experience, belief systems, values, fears, prejudices, hopes, disappointments, and achievements of the constructor."(p143)

- "The major task of the constructivist investigator is to tease out the constructions that the various actors in a setting hold and, so far as possible, to bring them into conjunction - a joining-with one another and with whatever information can be brought to bear on the issues involved." (p142)

- What is frequently taken to be "reality" is in fact a socially shared construction, at some levels the implicit agreement to work within broad cultural mores about how we should behave. At another level it may be an attempt to collectively and systematically come to some agreement about the state of affairs (e.g. science). Any individual's account of this will only be partial and shifting.

In their view, constructions are both self-sustaining and self-renewing. They are often held by individuals as 'truths' with a large degree of utility flowing from them, and are not given up lightly. They are open to change when the constructor is provided with new information which challenges them, and the degree to which they are changed depends on the nature of the information and the degree to which the constructor sees the need to move toward a more sophisticated interpretation. Such changes often occur in crisis according to the authors. Guba and Lincoln advocate that in the inquiry process all constructions are potentially meaningful and they must all be afforded an opportunity to be heard and honoured.

It is the perspective on 'truth and reality' and the implications for inquiry which these assumptions offer, and which led me to selecting them out to help me address my early series of questions regarding writing. However, there were to be contradictions between my theorising and my own experience which became painfully apparent in time.

Warrants from Naturalistic Inquiry.

Lincoln and Guba (1985) offer a set of criteria for judging the quality and rigour of inquiry within their model of Naturalistic Inquiry. The term they use is *Trustworthiness* and they offer some criteria and operational guidelines for establishing this. Trustworthiness is defined by the question "How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of?" (p290). I have described earlier those dimensions of Naturalistic Inquiry which appealed as having something to offer my inquiry purposes, and consistent with these I selected out criteria of trustworthiness which seemed most useful to my purposes in writing. These are the ones which seemed to me to best fit the constructivist position - that knowledge is a human construction never able to be certified as absolutely or ultimately true, is problematic and ever changing, and comprises multiple perspectives.

- *Credibility*: This can be established by: prolonged engagement; persistent observation; use of multiple sources (types of information and ways of obtaining the same information); use of multiple methods and multiple theories; peer de-briefing.

- *Transferability*: This can be aided by a 'thick description' (Geertz, 1973) of the research field, so that an audience can identify the elements of setting and contexts in which the inquiry was conducted sufficiently to know how applicable the findings are to their own settings.

There were several other criteria which I could not see fitting either Cooperative or Collaborative Inquiry and which seemed uncomfortably close to traditional criteria of reliability and validity. In many aspects of their methodology I see an implicit framing of the researcher as someone who is an 'outsider' who either temporarily joins a system then departs after the inquiry, or alternately maintains a distance from the action. Whilst the role of 'outsider temporarily joining the system' is an appropriate role for certain types of inquiry, it did not suit my purposes. However, there were things of value for my purposes, where I was an 'insider', and a participant as well a researcher. In their terms, I was also a 'stakeholder'. It was this frame which informed what I took from Lincoln and Guba's Naturalistic Inquiry.

In a later work on evaluation, Guba and Lincoln (1989) observe that their earlier criteria for quality and rigour have an over-reliance on method and an under-reliance on the role of constructions, thereby linking them implicitly with traditional research models. They develop criteria more consistent with the constructivist philosophy, relating to a concept they call *Authenticity*. There are five dimensions to this as follows.

- *Fairness* - the extent to which the different constructions and their underlying value structures are honoured.
- *Ontological authenticity* - the extent to which the participants' own constructions are improved, matured, extended and elaborated over the course of the inquiry, to the extent that they have more information and are more sophisticated in its use.
- *Educative authenticity* - the extent to which individual participants' understanding of and appreciation for the construction of others outside their stake-holding group are enhanced.
- *Catalytic authenticity* - the extent to which action is stimulated and facilitated by the evaluation process.
- *Tactical authenticity* - the extent to which the stakeholders and participants are empowered to act.

Lincoln and Guba (1990b) suggest a set of related criteria for judging the quality of case reports, whereby the writing about an inquiry ought to reflect the values and frameworks inherent in the conducting of the inquiry. These are summarised as follows.

- *Resonance criteria*: There ought to be a degree of fit, overlap or reinforcement between the case study report as written and the basic belief system underpinning the paradigm the researcher has chosen to follow.

- *Rhetorical criteria*: It should display unity: (be well-organised, contain some central idea easily discernible to the reader); should display simplicity or clarity; and should display craftmanship.

  Craftmanship has a series of dimensions as follows: has power and elegance; is creative; is open and problematic; shows awareness of writer's own constructions; displays courage; shows emotional and intellectual commitment to constructions advanced; displays egalitarian stance towards others.

- *Empowerment criteria.* It shows that authenticity criteria have been addressed in the inquiry.

- *Applicability criteria.* The case study enables the reader to draw inferences which may have applicability in her or his own situation.- for example readers have a 'deja-vu' experience, discern metaphors which speak to their own experience, and re-examine their own construction in relation to the phenomena discussed. This elaborates upon transferability criteria.

These felt to me to be very stretching, demanding and rather daunting criteria. But as I was not yet doing 'research', this was a first attempt at trying to strive toward some of these criteria. Credibility, Transferability and Resonance seemed within reach. I was working on developing the Rhetorical criterion in writing, and from there I thought I could try moving toward Fairness, Catalytic, and Tactical Authenticity.

Warrants from Cooperative and Collaborative Inquiry.

I have grouped these two together regarding quality of knowing criteria because I saw them as interrelated in practice through their emphasis on knowledge-in-and-for action. Cooperative Inquiry has a set of validity criteria (Reason, 1988) which pertain to its fuller forms and are embedded in the processes by which inquiry groups are conducted. Nonetheless, at this stage, there were several associated concepts which I saw as contributing to rigour of inquiry which I could use, even though I had not yet begun the 'research proper' and fulfilled my intentions to start a Cooperative Inquiry group.

- *Interpenetrating attention span* - as advocated by Torbert (1981). This had early implications for both reflection and action. It seemed a useful framework for thinking about interrelationships within an organisation and as a model for guiding the 'reflection-in-action' of myself as an individual. Torbert operationalises this for use in practice at the level of interpersonal dialogue and I will refer to this in more detail when I attempt to use it in practice. I thought stories should show the extent to which I was able to notice the interrelationships between purpose, strategy, behaviour and outcomes, both within myself and also between individuals, groups and organisations.

- *Critical Subjectivity* - as advocated within Cooperative Inquiry (Reason, 1988). I would need to demonstrate how I approached finding the 'critically subjective' stance, where I

was noticing the interplay between my personal process and events in the 'objective' world. From clinical practice I knew this as an analogue of 'the observer position' so felt I could at least partly meet this as a criterion for quality knowing. Critical subjectivity is more a conceptual category covering many different activities (an interpenetrating attention span could be an example), but it seemed a useful 'shorthand' to keep in the foreground to alert me to my own stance.

- *Heron's extended epistemology.* Any research or inquiry findings should display a grounding in, and a moving between, all four ways of knowing - experiential, presentational, propositional and practical.

- *Cycles of action and reflection.* Both Cooperative Inquiry and Collaborative Inquiry primarily intend to produce knowledge for action and within action. Each contains a dimension of cycling between reflection and action. Heron (1981) talks of two dimensions of experiential research, phenomenological mapping and intentional acting. The former is noticing, awarely discriminating and categorising what is going on, being fully open to the phenomena in question. The latter is the trying out of some developmental procedure which follows from hypotheses held about persons. Full experiential research requires a complementarity between the two, "between experiential receptivity and active agency" (p160). I felt my accounts of inquiry should gain a sense of how I was managing this complementarity.

- *Authentic collaboration.* The reader should be able to discern how I was seeking to create the conditions under which authentically collaborative relationships could occur within the field of inquiry. This was to be a source of considerable dissonance for me as I saw a full-blown Cooperative inquiry as the ideal but could not achieve this within the limitations of the setting and my own way of working. It took even longer to explore the possibilities for and limitations of collaborative practice and this quest underpins my research journey.

Warrants from Family Systems theory.

I am presenting one set of theoretical ideas from within the broadly based approach of Systemic Therapies which historically were influenced strongly by the work of Bateson (1972,1979) and Watzlawick, Weakland and Fisch (1974). However, more recently, in what is referred to as the 'Post-Milan' approach, social constructionism (e.g. Gergen, 1985) as an epistemological framework has increasingly taken a strong position in the foreground of theorising in the field. It places emphasis on the social process by which knowledge and meaning is derived. Knowledge is co-created through interaction between individuals, is shaped by the conventions of language and other social processes, and is historically situated. Through the process of teaching and the preparation of materials and exercises for trainees, I began more consciously to bring this framework for thinking about practice into the foreground and tentatively explore its utility for me.

Cronen and Pearce (1985) offer a tentative "Systemic epistemology", rooted in social constructivist ideas, to aid theorising about the evolution of family systems. For my purposes, it offered a specific conceptual framework for thinking about the interaction of beliefs, behaviour and relationship in making sense of events I was participating in and wishing to present in writing. The starting point for their model is the view that the structure of a family lies in the relationships among members and is tied reflexively to action - whatever action members engage in both expresses and reconstitutes the structure of the family system. Because individuals are always acting in the world, and because of this reflexivity, Cronen and Pearce theorise that the family as a system evolves over time (although not always without pain). The content and organisation of structure emerges out of conjoint action and is always in a process of emergence.

Their proposal for how meaning is managed within families is based on two claims. One is that all social structures entail ways of managing consciousness or awareness of the various elements of those structures. The other is that social actors organise meaning both temporally and hierarchically and it is this aspect I wish to draw upon. The authors conceive of social meanings as hierarchically organised so that one level is the context for the interpretation of the others. They propose a number of embedded levels of context in which one or more can become the context for attributing meaning in another. Thus the social actor 'punctuates' sequences of events and makes sense according to whichever level of context is operating at the time. The number of embedded levels is not fixed, but they suggest five for the purpose of understanding how meaning is managed within families.

- *Family Myth*: Higher order general conceptions of how society, personal roles and family relationships work.
- *Life-Scripting*: A person's conception of self in social action. For example "I am intellectual and sceptic".
- *Relationship*: A conception of how, and on what terms, two or more persons engage. For example, part of a relationship concept might be "I am the initiator, he/she is the follower".
- *Episode*: Conceptions of patterns of reciprocated acts. For example, "Our usual fights are over who gets to use the car".
- *Speech Act*: The relational meanings of verbal and non-verbal messages. For example, "promise " and " conceding the point" take on meaning from the episode in which they occur.

Each of the five is a marker for a complex of information at a particular level of abstraction, and they are arranged hierarchically from the more abstract and general to the particular. There is a reflexivity among the levels, although the nature of this reflexivity changes over time. For example, for a couple who are in the early stages of getting acquainted, the nature of their

relationship is very sensitive to the conduct of a particular episode. However as their relationship begins to emerge it in turn will come to have a stronger influence over how any particular episode is interpreted. Overall, the longer the history of relationship, the more powerful the downward influence of the higher order levels of context become and the weaker the upward influence of the lower order.

Cronen and Pearce propose a model for understanding the interactions between different levels of context, and between context, meaning and action within families. They also offer perspectives on the interaction between consciousness and structure, each being a by-product of the other. Consciousness is organised according to how individuals are positioned by language and perceptions of roles, duties and responsibilities. However, it is not my purpose to enlarge on this here. I wish to present only the idea of an hierarchically arranged series of embedded contexts as an aid to 'making sense'. I saw it as having use in the world of work. I wondered about another level of context, namely that of 'organisational myth' which contains socially developed conceptions of 'what this organisation is about' and 'how we relate to the wider world' and 'how one is meant to act within the organisation'. This can be an additional level of context containing constructions for understanding and guiding relationships at work, in interplay with the others.

For me, this was a framework from the world of therapy which I was exploring and which I thought a potentially useful aid in thinking about relationships and making sense of them. I believed that it would be a warrant in my writing if I could convey the interplay between action and differing contexts for making sense as I perceived it - not in rigidly held 'this is truth' terms, but in lightly held and emergent terms of 'this is my best guess at the moment which could be changed with further information from a different vantage point'. As Cronen and Pearce comment, "No social system can operate with near total consciousness of its own structure from a third person position at all times. Try falling in love that way!" (p83). This comment rang true. Without holding dear to favourite truths how can one have the necessary degree of passion or commitment to engage in long term development. The challenge is to know when favoured truths are hindering and not helping.

A warrant from critical theory.

Although I have made some observations already on the relative merits, as I see them, of critical theory and constructivism, I would like to include an explicit statement here about the value I saw in a critical theory position as I began exploring methods of inquiry.

Critical theory seeks to work towards transformation as if some central truth/s existed. It captured the idea for me that some deeply held values are not very open to change (unless major crisis/es lead to a paradigm shift) and therefore act as fundamental truths. This honours the 'reality' of day to day experience. A constructivist positions provides a position from which one may stand and notice some of these 'truths' and allow for a reviewing of them in the light of new experience and new knowledge. But a critical theory position allows for fundamentals or

essences about human nature and the universe, these are necessary as foundations for full engagement in what one is doing (akin to the third stage of coop inquiry, where the individual brackets off initial hypotheses and theories about experience and fully engages in practice)

A comment on warrants from theory.

The above set of criteria did not capture the sense of reflexivity I came to experience in my relationship to writing, where writing became a form of inquiry in itself, 'writing me' as I 'wrote it'. This process is captured more by the narrative inquiry framework which came much later. Therefore these criteria were useful as a starting point, rather than an ending point. I used them as aids to a 'critical subjectivity' or reflexivity in the following ways.

- By noticing my own and others' constructions and how they were operating as best I could, as problematic, shifting and indeterminate.
- By using the construct of embeddedness of context to look at relationships and the actions within them - this would be one schema for noticing and commenting upon my own construing.
- By describing the situation, the action and the contexts which were operating for me.
- By being explicit about my own 'truth-positions', thus providing an edge, a standpoint from which to notice, comment and make sense.

Warrants from clinical practice

These felt most familiar to me and are ones in which I felt most experientially grounded and confident, and to that extent they probably informed my writing more actively than the warrant from theory. However, there are varying degrees of correspondence between the two sets of warrants. Those from theory elaborated upon and in some cases 'warranted the warrants' from practice, whereas those from practice implicitly operationalised some of the theoretical constructs from theory.

In order to describe this warrant it is necessary to first of all trace the development of some key influences on my clinical practice. In first moving away from the individually focused models towards the *interactionally focused models* under the family systems umbrella, I was influenced by the work of Watzlawick, Weakland and Fisch. Three influential concepts were:

- The distinction between *first order* and *second order* change based on mathematical Group Theory and the Theory of Logical Types. First order change occurs when the elements in a system change but without any change in the rules governing the relationship between the elements. Second order change occurs when the rules governing relationships change and hence the system moves to a different level of functioning.
- The distinction between *digital* and *analogue* communication. Digital equates with 'content' and analogue with 'process'. Digital consists of a class of message where a

statement has only one referent which has previously been defined. It is precise, logical and literal. It is best used to describe people's relationship with the physical environment, for example building a bridge.

Analogue consists of a class of message where a statement has multiple referents. It is capable of having different meanings according to the context in which the communication occurs. It has an 'as if' quality, equates with metaphor, and is best used for describing the relationships between people. Analogue aspects of communication provide a 'meta-communication' about digital aspects, commenting on implicit or explicit rules, who sets them, and what is allowable. Both are necessary to allow for the complexity of human experience.

- *Reframing.* This concept is defined by Watzlawick, Weakland and Fisch (1974) as "To change the conceptual and/or emotional setting in relation to which a situation is experienced and to place it in another frame which fits the "facts" of the same concrete situation equally well or even better and thereby changes its entire meaning". (P95) Reframing opens up the possibility of new solutions.

The development of these ideas were significantly influenced by the work of Milton Erickson whose unique approach to change was based on his use of hypnotic procedures to shift and expand individuals' appreciation of themselves and their situations, and to utilise solutions available within this extended awareness. There have been numerous attempts to describe his approach and to capture the essence of what he does. Hayley's (1973) account provides two metaphors which stayed with me.

- Change should be like creating a snowball by letting it roll down hill.
- Solution's are contained within the problems which clients bring to therapy. Use what the client brings to you.

The practice which is required in order to bring these metaphors to life within therapy consists of paying very careful attention to the *language and the metaphors* the client/s use. It also consists of using the clients goals for change as the goals for therapy and this entails careful inquiry in the early stages to solicit these. Working with the client to help them move from problem to solution requires starting from within their frame of reference and expanding this so that new perspectives and hence new solutions become available. The *telling of stories* and use of metaphor by the therapist is one means of expanding these frames of reference. These may be stories about 'other clients I have worked with', stories from literature, or stories deliberately crafted which contain metaphorical representation of the client's experience together with possible alternatives available to them. This approach contained implicit recognition of multiple, local and partial realities. The telling of stories may be sufficient in and of itself, or it may require directives from the therapist which help the client pay attention to aspects of their experience to which they had previously been unaware.

Another influence on my practice has been the concept of the *individual and family life cycle*, informed by different models of development across the life span. A central metaphor for me within this is one of *transition and change*. It is typical that individuals and families experience problems around times of transition which require the re-negotiation of relationships with themselves, each other and the wider world. Transition connotes *dilemma*, where there are choices to be made about how the transition is to be negotiated. The task of the therapist is to surface the dilemmas contained within the presenting problems and explore the alternative possible means of resolving or transcending them. This occurs against a background appreciation of 'real life' tasks, duties, responsibilities and so on which face the different family members according to the particular developmental requirements of the life cycle.

So, my clinical practice is informed by careful listening for language and metaphor; joining with people to understand 'how it is for them' and starting at their 'pace'; listening for *stories* and telling stories; and looking for who else is in the field who can contribute towards success.

One means of telling stories and using metaphor is through *letter writing*. This can be used at different stages of the therapeutic process according to what the therapist is wishing to achieve. It can be used to engage people, to join with them and check out that the therapist has sufficient understanding of 'how it is for them', to surface dilemmas in a way which the client can 'hear', and so on. I use letters from time to time for these purposes and see them as a means of inquiry - noticing effects of the letter according to my purpose, sometimes directly inquiring and sometimes merely noticing according to the nature of the relationships and context in which the letter was sent. More recently, letter writing has been elaborated upon within a social constructionist framework which emphasises the narrative aspects of experience, and letters are used as a means of helping clients 're-author' their *life narratives*. White and Epston (1990) are two such writers and are individuals I have worked with in the early 1980's in New Zealand. I learned from them some of the 'craft' knowledge required to use letters in an empowering and affirming way. However, at that time much of what occurred under the family systems umbrella was experimental and under-theorised. Narrative metaphors and a constructivist/social constructionist epistemology were not present as theoretical frameworks.

My continuing use of these practice skills and approaches is affirmed by the regular feedback I get from clients and colleagues. A frequent question is "how do you remember all these things about me?" My answer to myself is that I listen for the stories in their lives, not only the stories which contain problems, guilt and blame, but also the stories implicit or only partially told about strengths in the face of adversity and about possibilities for transformation and change. These stories become the scaffolding upon which hang the details of their lives. I retain the scaffolding and the details present themselves to me when necessary according to the nature and requirements of the particular conversation at hand.

A current colleague once commented that she enjoyed reading my written assessments and care plans in the case notes of clients for whom I required the involvement of other team members. "I feel that I get a picture of who they are and what their lives are about and what they want from us before I get to meet them". On inquiry, the characteristics of my writing which created this impression was the sense of story, the description of salient features of the clients life situation, goals for change and help required written in the clients language, together with my own observations and impressions.

A clinical practice illustration using letter writing.

I would like to illustrate these aspects of my practice by giving an example of how I used a letter to engage a client in the process of change by letting her know I had heard her story about shame and powerlessness, but also offered her 'another story' which I had heard implicitly in her life which offered more liberating possibilities.

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Sheila was a gently mannered woman in her fifties who had drifted into alcohol misuse over the course of her married life. She and her husband had run a joint family business together but she had left this several years ago to care for her ageing parents full-time and they had both died in the past year. She had reached the point now, at a major transition time in her life, where she was depressed and grieving, and where her dependent use of alcohol was contributing to personal, marital and health problems. She was consumed with shame about this, to the point that she was unsure whether she was able to change and was unsure whether she was entitled to professional help. She pictured her husband as someone who was "disgusted" by her drinking, but also recognised that this might be a position he took to galvanise her into action.

On the other hand, Sheila was also ambivalent about giving up her attachment to alcohol and the short term relief from distress it provided her. If I were to successfully engage her, I felt the issue of shame needed addressing first. At the end of the initial session, she made several comments: that she felt unable to stop drinking altogether and so wished to try to control it first before considering other options; and that she was not sure she could be helped because she could not find " a reason" for her drinking - there had been no obvious adverse circumstances in her life until recently. My assessment was that she was unlikely to succeed in her stated goals on her own, and I wanted her to feel she could return when she was ready, but from a position of more hope and less shame. My intention was to give her another perspective on herself and her situation which fitted closely enough with her experience (as I had discerned it) that she would feel it 'spoke to her', but different enough that it would offer some possible ways out of guilt, blame and isolation. I also wanted to place it in a more 'normalised' and interpersonal framework which would alert her and her husband to the changes in relationships which would need to be negotiated for growth and transformation to occur.

It will be apparent to the reader that there are other frames in addition to the ones I mentioned which inform this letter (such as assumptions about gender), but it is not my purpose to enlarge upon them here. I have changed those details which in any way may serve to identify Sheila.

"Dear Sheila,

I thought it might be helpful if I wrote to you summarising our recent meeting as I understood it, and outline the options as I saw them. In thinking about your situation I have borne your husband in mind and I would be quite happy if you wished to show him this letter.

As I understood it, you are currently adapting to the very painful loss of both your parents within the past year. However, you told me that this fact alone does not help you understand how it is that you have become so dependent on alcohol over the years. As I heard it, you feel there have been no real problems in your life, having two healthy children and now grandchildren, having had a very busy and satisfying working life where you enjoyed a good working partnership with your husband, having a comfortable home, and managing to have enjoyed your parents despite the fact that they required a considerable degree of care and support from you in their later years.

The lack of any obvious "cause' for your drinking seemed to leave you feeling very puzzled and without anything tangible to tackle in order to overcome it and the deeply held sense of shame you experience because of it. Nonetheless, you are at a point where you are thinking that things need to change even if at present you have no clear idea about how you might create a future for yourself without alcohol.

From my point of view, you share many issues with other women I see at a similar stage of life. They have spent nearly all of their adult lives being daughters, wives, mothers and, in later years, parents to their own parents as they need increasing care and support. Frequently they have had little space in their lives to pay attention to the 'individual' part of themselves that may have only been partly developed before these other roles took up so much time and energy. Many such women have found, each in their own individual way, that alcohol could help fill that gap or provide some 'space' for themselves.

So, in reaching a stage in their lives where their children have left home and where they no longer have parents to care for or turn to, they face major changes. It is a time when couples have more time to be a couple and need to re-negotiate what sort of relationship they want together. It is a time when each of the couple are faced with finding other ways or new ways of finding fulfilment as individuals. For men that may mean looking outside their working lives, particularly if they are facing retirement.

For women, it may mean a different challenge as they are very often out of practise in thinking about their own needs. Alternatively, they may face a crisis of confidence in

moving outside the home if they want to re-enter the paid workforce. They may discover that they also feel isolated and lack confidence in making new friendships outside the home. Recent bereavements can make this doubly difficult because that necessarily involves some time dwelling in the past before being ready to move into the future.

Overcoming alcohol problems, no matter what the original "cause", requires that individuals find some way of sorting through these issues in their own way. This is not always easy and can seem rather daunting initially. In my experience, if one member of a couple begins to make some changes without the involvement of the other, then that can place a strain on the marriage. For this reason it is important that they be involved in the process.

In relation to your current situation, my opinion is that you will need an alcohol free period of at least several months to take stock of things and to assess for yourself how much your feelings at present are due to you and how much is due to alcohol. If you feel you cannot achieve this on your own then we can talk further about how I can help with this. One thing is clear to me, that alcohol will only eventually take a back seat in your life when you have other things in its place. Coming for help was one of a number of steps you have taken to begin this process. I would be happy to see you again, either by yourself or with your husband, if you would like to discuss this further.

Yours sincerely."

Over the course of the next few months, Sheila wrote several brief letters to me, saying that things had essentially not changed and that she would probably need to come back to see me. Eventually she wrote saying that she had been unsuccessful in controlling her drinking and that she needed help in stopping altogether. I arranged for her to stay residentially in the clinic for detoxification followed by a several weeks of rehabilitation in which she worked with various staff in exploring the changes she wished to make. By the time she was ready to leave, she had already started towards some of her goals. On the day of her discharge she approached me in the corridor to thank me. As we parted, she turned back to say, "Do you remember the letter you wrote to me last year? That described me exactly!"

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Commentary on warrants from theory and practice.

There were two levels or domains of use for which I developed the above set of criteria. One was to inform my research action, the other was to inform my writing about it. The tension which was to pervade for sometime was that I had bracketed off current behaviour as 'practising for the research proper' which I had envisaged would begin when I gained the full and explicit collaboration with colleagues as co-researchers in a Cooperative inquiry. In the meantime, my action in the field was 'merely practice' and my writing about it in story form felt less than fully authentic because I did not have such full collaboration, as I saw it. So although I felt authentic in writing about my own actions and experiences, I was bothered

about the authenticity of writing about others in the field because I had not gained the mutuality of commitment and fullness of explicit collaboration I intended.

As I began writing and recording my research experiences these were the things I took with me. I was not clear how I would use them in the sense of priority or importance, but I carried them with varying degrees of awareness and they lay behind and within the action and the writing processes. They seem a large 'tool kit' to carry, but nonetheless carry them I did. Some of them intersect and overlap with each other so that the use of one implies the other. Some criteria were activated in certain contexts, others in different contexts. In other words, although they were carried, and potentially always available, some occupied foreground at any one time while the others remained in the background.

The application and development of these ideas in practice will weave itself throughout the remainder of the research, and I will comment on their use when I notice their presence.

6. FINDING A FOCUS FOR RESEARCH AND INITIATING A COOPERATIVE INQUIRY

Introduction

At this point in the research my intentions were to invite interested colleagues from different professional disciplines to join me in a Cooperative Inquiry in order to research into aspects of multidisciplinary team work. Although I had my own broad questions I wished to explore, within my understanding of Cooperative Inquiry I would need to hold these somewhat lightly at the outset, in order that the inquiry group once formed could then negotiate collaboratively with each other what the focus for research would be. However, I felt I needed to have more of a focus for inviting people into a research venture than a loose set of questions. 'Teamwork' as such did not feel as though it had much 'bite', and nor did it seem congruent with what the agendas were in the department at the time.

The department was still in the early stages of the making the massive changes I outlined in Chapter One. Many of the longer-term staff were finding the changes in roles and relationships had left them feeling de-skilled and unsupported. There were differing views across the department about how we should implement the changes we had agreed upon in a series of planning days. And there were conflicts of interest, particularly between the two consultants.

We had agreed a structure for communication and decision-making for the department and part of that had been the formation of a Core Group which worked with the Clinical Director (William) and Service Manager (Jan) in taking responsibility for the overall direction the services should take. Stewart (the second consultant), a social worker and I made up that group. Together we represented the different disciplines and each had some responsibility for how the budgets and resources were used.

We then had a larger operational group which made decisions about day to day running of the service, and membership of that comprised those people who had responsibility for providing the different components of the services. Membership included the Core Group and leaders of the various small teams providing services within the department.

My clinical practice roles were centred in the hospital-based services, supporting the development of new outpatient clinics and supporting in-patient services where clients were admitted for assessment and detoxification from drugs and alcohol.

Within the context of my hopes, aspirations and intentions with which I had joined the department, I was seeking to join with people, to support the changes by working alongside individuals and teams, and to find where my particular set of skills could be best used. Within the context of the relationship between the two consultants and their relationships with the rest of the staff, I felt that I had to mask my skills and experiences. I had already witnessed head-on and unproductive clashes between the consultants and others over 'how things should be

done'. I wished to avoid these if possible and seek to promote cooperation. I had no wish to repeat my early experiences in the acute psychiatric ward of taking the public position of 'this is the way to do things'. I was a lot more respectful of the different ways the professional disciplines saw their roles and the nature of the problems we were all dealing with. I knew that if I was to be successful in supporting change I had both 'go with people' and 'take people with me'.

Within this setting then, I was preparing to set up a research 'project'. This chapter is about:

- 'Testing the water' for a Cooperative Inquiry.
- Finding a focus for such an inquiry which would hold my interests and engage interested colleagues in joining me.
- Initiating a Cooperative Inquiry, and finding myself stumbling.

Testing the Water.

My first testing of the water, tentatively inquiring into how receptive my colleagues would be to both working with me and to working within an unfamiliar research paradigm, was through a weekly departmental seminar. I was asked to contribute a topic, so offered to talk about "New Ideas in Qualitative Research". I presented ideas from my readings to date, talking about the transition to a new paradigm, the key assumptions underlying it and the old paradigm, then moving to a description of Cooperative Inquiry and Collaborative Inquiry.

The two consultants were the main participants in the discussion. Each was keen on doing research and Stewart held a part-time research position in the medical school. William attempted to understand how research could be done without a starting hypothesis to test out. Stewart was considerably more challenging, doubting the relevance of any concern with epistemology or ontology, and questioning some of the terms and language I was using. I felt him to be sceptical and although I was not surprised by this, I nonetheless felt a little on the back foot. However I 'held my own' in this encounter, although by the end of it Stewart concluded that this way of doing research was not really a radical departure from standard social science research, it was merely articulating the softer end of it in unnecessarily complicated language.

I felt a mixture of reactions to this. I was intrigued that I had probably witnessed what Guba and Lincoln (1990) had described as a 'post-positivist response', a reframing of new paradigm ideas back into the epistemological and ontological framework of the traditional paradigm. I wondered if in fact I had not 'held my own' but rather had colluded with this in some way in the face of the challenge. But most importantly, I was left feeling vulnerable and uncertain about the degree to which I could proceed with a research project on multi-disciplinary teamwork with people who evidently did not share my frameworks. How could I engage in open and authentic collaboration? If I was to reveal the ways I conceptualised my work, would I receive the same reception? As a practitioner I was used to the contradiction of working with people

despite the differing frameworks held, but how could I bridge this gap as a researcher within this paradigm?

I was sure that Cooperative Inquiry was the most suitable framework. It had a bias for action, and it provided for direct involvement of colleagues in a collaborative venture which would allow us all to own the outcome and increase our commitment to the products of the inquiry. The process would allow for the negotiation of differences and similarities in world-views about teamwork and about practice. Yet I felt very apprehensive about my ability to convene and lead one. The seminar had surfaced my doubts and vulnerabilities. I did not see that the method was perhaps not the best approach for the circumstances, it was more the case that I was not up to it, had not got the nerve to take risks as a researcher. I was not prepared for the rejection I foresaw might happen.

Following this I went through a period of self-doubt and confusion as to how I could proceed with a Cooperative Inquiry into multi-disciplinary team work. In supervision I was offered the alternatives of staying with the confusion for a bit to see where it lead, or alternatively, broadening my focus to look at the broader organisation within a systems model - linking two themes I had expressed some interest in.

I resisted the former. Research to me was primarily a social process, therefore to focus on myself, as I heard it, at this stage felt self-indulgent. I read some social psychological literature around the latter possibility but it seemed to go to the other extreme, placing the researcher outside the action as an observer. Neither seemed to fit my requirements.

I decided to continue 'noticing' in a more conscious way as I went about my work, looking for openings or possibilities. As a practitioner I felt accepted and affirmed by colleagues, but as a researcher felt I was not 'getting off the ground' unless I could find a way of starting a Cooperative Inquiry group. I wondered if there was another way of getting colleagues to join with me. Although teamwork certainly was an issue as far as I saw it in the developing service, it felt lacking as a focus of interest for other people and I was beginning to wonder if it held the essence of what I was really interested in.

Finding a Focus

After some time of paying more conscious attention to my practice, keeping reflective diaries and journals and notes, I realised there was an emerging pattern in how certain clients were dealt with in the in-patient unit . In my noticings I became aware that in each of these episodes I played similar roles, and there had been patterns within connecting them to elements of my work across a variety of settings in the past.

These episodes engaged my interest for several reasons. They were characterised by crises which seemed to stress both client and staff, but which did not seem to lead to any reflection about how to resolve differently next time. All the different disciplines were involved at some stage but there did not seem to be any clear direction in care planning or clarification of who

was in charge of the case. I found myself drawn in by these characteristics, to try and remedy the situation because I believed the chances of a more successful outcome would be increased if they were addressed.

Such episodes beckoned as a possible focus for inquiry. They engaged me as a practitioner and they seemed to be a site which connected with many of the questions I was considering for research and seeking to understand with more rigour. Perhaps colleagues would find this an interesting and important aspect of practise and teamwork to investigate and improve upon through an inquiry group.

I wrote accounts of several of these episodes, and in doing so used several lenses from research theory, as well as several from clinical practice. I did not see this as inquiry at the time. I saw it as preparation for the research 'proper', in which I was exploring some of the criteria for quality of knowing from the research methodologies.

I have several purposes in presenting one of those account at this point. It is an example of my beginning engagement with writing and with use of storied form as research account. The writing of it was informed by the various warrants described in the previous chapter. At the time of writing I was noticing in practice how I developed critical subjectivity and how I moved between Heron's four different ways of knowing. I was noticing the extent to which I used reflection in action, and for action.

In writing the account I sought to describe these processes to myself and others in a way that was alive and which incorporated some of the warrants I took from Naturalistic Inquiry - I wanted to begin making explicit some of the various framings, values and constructions I held in practice. I was also wanting to record descriptions of the setting, the characters in it and the developing relationships with the sense I made of them. At the same time I was still seeking for 'niches' in the department where there was a degree of fit, or mutual adaptation, between what I was seeking and what was needed or accepted. Through the process of writing such an account I discovered how resonances between the present and the past surfaced, and how this informed my actions. The following episode surfaced how I brought with me ideas about the role crises can play in change; ideas from therapy about the importance of meeting people 'where they were at'; and ideas from experience in the Whare Paia about 'holding' people and providing a 'place to stand' when they were in states of alienation from self and others. (The NZ Maori have a term 'Turanga wai wai', roughly translated as 'having a place to stand' - this was an essential component of mental health, referring to spirituality through connectedness with the earth as well as a specific tribal location for belonging).

I include this story here as I wrote it in its original form, including some small changes in response to comments on drafts made at that time. I used various 'voices' for the participants: those of myself variously as narrator, as reflecting on the action, and as commentator about theoretical perspectives; and those of other participants in the action in dialogue form. The

dialogue is my reconstruction, taken from case notes, reflective diary entries written at the time and from my notepad which accompanies me everywhere and in which I make notes in the midst of conversations, therapy sessions, meetings and so on.

I used this form out of an intuitive sense of how best to convey to myself and others as audience how it was I engaged in action, how I paid attention to dialogue (both internal and external), how I used metaphor (presentational knowing) and how I reflected for action. I see it in retrospect as a marker point for tentatively and unawarely using 'noticing practice' and 'story telling' as forms of inquiry. Through the framework of Narrative Inquiry and its attendant assumptions, I now feel more comfortable as presenting it as 'my story' which may well differ from the 'story' told by other participants.

Story telling as tentative inquiry

The story begins here.

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'Cushioning the Fall'

I visited the nursing office on the ward one morning to find a small group of staff looking out through the window at a man sitting on a nearby roof, several storeys from the ground. He was holding on to a chimney with one hand and to a bottle with the other, apparently drunk, and yelling a tirade of abuse at the ward staff. He had been discharged from being a patient on the ward earlier that morning and, amongst other things, was saying that unless he was allowed back in he would throw himself off the roof.

The staff were discussing how they should respond to this incident, apart from the routine crisis procedure for such situations which had already been initiated and which involved calling ambulance and fire services. A member of staff from another ward in the hospital, who was designated to respond to situations such as these, was on the spot ready to co-ordinate activities.

There was an atmosphere of tension and anxiety in the room and some people were expressing frustration and anger while others evidently saw a touch of black humour in the situation. William was joking about the patient wanting to stay with us and that we should offer endless admission. I have a dark humour which comes to the fore in such situations and for a moment I playfully joined William. I was interested that he could see the humour and paradoxical communication in a serious situation and felt there was potential to develop a good working relationship with him. But staying with the humour was not going to solve the problem and William was slipping into impatience.

- *Reflections in action*: "I can see what the anxiety is about and there is an implicit sense of melodrama, as if we are watching an old Charlie Chaplain or Keystone Cops movie. However I am puzzled by the anger being expressed toward the patient by Ms Junior nurse T who seems to be supported by Mr Senior Registrar J. This is a situation which

needs careful handling if there is going to be a safe outcome. It feels as if there is a risk of loss of face and dignity for both patient and some of the staff here if this is not resolved with tact. Without this there will be continued problems, whatever the immediate outcome"

As I listened to people talking there seemed to be conflicting views on how to manage the situation.

- *Dialogue:*

  [Ms. Junior Nurse T]: "We made a contract with this man on admission that he was here just for a detox and that he would be discharged today. If we let him back in it will be giving in to this manipulative behaviour. He has been a real problem and we have had to set firm limits with him throughout his stay."

  [Mr. Senior Registrar J]: "I agree. This man is a personality disorder and if we back down and let him in he will 'split' the staff and he will be difficult to manage".

  [William]: "This is silly. He can't stay up there, it is dangerous. We have got to get him down somehow, and besides, our job is to treat people not play silly games. Promise him anything but get him down then we can sort it out."

  [Mr. Senior Nurse D]: "What I am worried about is who is going to do this. It is the Senior Nurse-On-Call's job to co-ordinate the ambulance and fire brigade but the patient is ours and we should be the ones to negotiate with him. Already there are several people out there and it could get confusing."

It was at this point that I began to wonder whether or not to become involved in a more active sense.

- *Reflections-in-action:* "William is not actually taking charge in determining how this will be solved. It needs somebody to do this if there is to be a creative solution. William will be open to any way of getting him down and I think he would listen to me if I were to offer a way. I don't know why he doesn't take charge as it is his usual style to do so, often too readily. Perhaps he doesn't want to undermine the Senior Registrar or get into a public dispute with the nursing staff. This feels a familiar conflict and I don't want to undermine him or put him on the spot.

  On the other hand I know from discussions with Junior Nurse T that she is finding the transitions to working with drug users difficult and that her recent nursing training hasn't equipped her for this. I would like to find some way of supporting her to see this through and develop her skills and confidence. She is young in experience and tends to paint herself into corners. At the end of the day it is the nursing staff who have most to do

with the patients here and I think I could play a useful role in supporting them to develop some skills they do not appear to have.

I think that Mr. Senior Registrar is joining with the nurses in the way that doctors in training do because that is where they get most of their support.

If I get involved here I run the risk of adding one more 'cook' and 'spoiling the broth' and that may add to the problem. They will handle it in some way and it is tempting to leave at this point. On the other hand this is a crisis which presents a good opportunity for introducing some change and testing out how well we can work together around difficult situations. It feels timely to get some teamwork going. I am not sure how this situation arose and I don't have enough information yet to know how to introduce a plan that will get some agreement. I need a few minutes getting a broader picture."

- *Comment* on 'theory and past experience lenses' I was using at this point:
  Here I was informed by a theory of crisis intervention which held that a crisis was most usefully viewed as a time of opportunity for change and that a crisis signalled that a network was facing instability because of loss of resources. This loss could be interpersonal, economic, legal, or political (influence). At times of crisis people are more open to change and accepting of intervention. It is possible for a crisis worker with this orientation to intervene in such a way as to help the network in question both solve the problem and develop more resources to solve similar problems themselves in the future. The strategy is to gain an initial concrete definition of the presenting problem with which all can agree, even if it seems minor or unrelated to apparently larger or more serious problems. The next step is to discover who is in the network, assemble the members or visit them sequentially, and clarify who and what is necessary to solve the problem. The art is to then exit as quickly and as gracefully as possible. I brought this theory and experience in practice with me into this situation.

I inquired into some of the background to the patient's being here, asking about where he came from, who had referred and why, what problems he had presented to the ward staff, what follow-up arrangements had been made and what was known of the patient's view about his current situation.

- *Comment* on 'theory and past experience lenses' I was using at this point:
  Minuchin's (1974) Structural Family Therapy model informed my inquiry here. I had found the concepts of 'sub-systems' and 'boundaries' useful in thinking about other groups as well as families. Sub-systems are groupings of individuals according to some common characteristic (e.g. gender and age), or function. Boundaries are an invisible set of rules giving membership to a sub-system and are defined by 'who does what with whom'. Boundaries are determined both by the group or family and by the wider culture. It is clarity of boundaries that is most important for growth and development as they define the degree of differentiation from and interdependence with other sub-systems and the

wider system. In Structural Family Therapy one of the therapists tasks is to help the family clarify and maintain boundaries appropriate to its stage of development and the task at hand.

It emerged that staff had found him to be very difficult to work with, viewing him as being very "demanding" and "manipulative" and as not responding to their usual ways of working. He would present the nurses with physical aches and pains with no obvious cause and demand immediate attention. If not received he would fall in a faint on the floor but always so in such a graceful manner that he never lost his glasses. They saw him as exaggerating and attention-seeking and had difficulty in taking him seriously.

The patient had arranged to enter a long term rehabilitation centre in several weeks time following his discharge today, but in the meantime had no accommodation to return to. This apparently had been smashed up by his drug dealer to whom he owed money and he was facing a number of legal and financial problems. Little of this was known at time of referral but emerged during his stay. As he had come from another Health District there had been confusion about who would take responsibility for co-ordinating his follow-up care with the result that no one had been clearly nominated.

This was another pattern within the services I had glimpsed previously. Within this context the patient's behaviour began to seem a little more understandable.

- *Reflections-in-action*: "I think enough of a consensus has emerged in this conversation that we might possibly be able to reach an agreement about where to go from here. I think everybody accepts that there has been a lack of initial agreement between the patient, the referrer and our service about what was wanted from the admission to our ward. It is clearer that we have been participants in this confusion and therefore have some responsibility to help solve it. So I think it will seem reasonable to offer an extended stay while follow-up is sorted out.

  Junior Nurse T and Mr Senior Registrar appear sceptical that he will behave himself if we have him back, so some way is needed of toning down the conflict and getting some co-operation going. I will need to stay in this and work with them if this is to happen, particularly if I argue for having him back. They will not feel heard and the conflict will escalate again if his contributions to the problems are ignored and the difficulties in working with him not acknowledged.

  Also, I don't know this patient and he may be someone who is well practised in using these strategies to gain entry to psychiatric facilities and to stay there indefinitely. We need to reframe his behaviour in some way that connotes co-operation with us."

I agreed with William that the patient should be offered re-admission and suggested that we should reframe his behaviour as helpful to us in pointing out that we had dramatically missed

the seriousness of his situation and that we had not yet completed our work with him in helping him prepare for the next step in his recovery.

I next offered to convene a meeting with the patient and relevant staff to clarify what further work was needed and to work with the nursing staff in finding some ways of managing the rest of the patient's stay which lessened the likelihood of past problems recurring. I affirmed the ward rules that nobody who had a breath-alcohol reading be allowed in the in-patients area and that this must be pointed out to him. Someone suggested he be offered the waiting area for the rest of the day and I took this as a small but significant sign that we were 'moving in the right direction'.

- *Comment* on 'theory and past experience lenses' I was using at this point:
  Here I brought in experience developed around ideas form the Brief Therapy school (Watzlawick, Weakland and Fisch, 1974). 'Reframing' means "To change the conceptual and/or emotional setting in relation to which a situation is experienced and to place it in another frame which fits the "facts" of the same concrete situation equally well or even better and thereby changes its entire meaning" (P95). Reframing opens up the possibility of new solutions.

The next day I attended the weekly in-patient case review and found that the patient had been re-admitted as planned. No mention was made of our agreement of yesterday to meet with the patient. I was surprised as I had anticipated they would be keen for it to happen in order to prevent further problems. This left me wondering if I had overestimated the degree of concern and whether this signalled a reactive as opposed to pro-active problem solving style among the staff. Was this a 'wait until something happens' approach? Was this part of a sequence of interactions where one party distances and the other party pursues? If so I could see what might have been maintaining problems between P and the staff. I reminded people of the plan to meet with P and clarified who needed to attend.

- *Comment* on 'theory and past experience lenses' I was using at this point:
  Jackson (1968) coined the term 'distancing pursuing sequences' to describe how family members negotiated intimacy. This emerged from early research into families with a schizophrenic member, using Communications Theory and incorporating Bateson's notions of complementary and symmetrical relationships. These sequences were observed to escalate until either violence or separation were threatened. They could begin again after a pause with the roles reversed. Jackson developed a classification of marriage types, including this pattern which he described as 'tied together by a ten foot barge pole'. While I find this a limited and partial explanation/description, I find it useful to alert me to certain possible outcomes when I discern this pattern occurring in relationships.

I met initially with Ms. Junior Nurse T, his key nurse, and Mr Registrar Dr S. who had been giving him direct medical care during the past two weeks.

- *Dialogue:*

  [Me]: "I thought we needed to meet together beforehand just to be clear about how we are going to run this meeting and to make sure we are in agreement. I see the purpose of this meeting as giving P the opportunity of telling us what he would like from us for the rest of the stay, and for us to decide what we can and can't do to meet this. I think it is very important that whatever is agreed is something we can all work with and that we get clear what each is going to do otherwise I think there is a strong chance with this guy that we'll end up back in the same situation as before. I am happy to start the meeting off with each of you chipping in as you wish. What do you think ?

  [Nurse T and Dr S]: (Nods of agreement but each looks uncomfortable).

  [Me]: "You don't look comfortable about this."

  [Nurse T]: "I don't feel very optimistic about this at all. He is so histrionic and difficult to work with. No matter what I do or what limits I set it doesn't work. I've been through this with him already and have made contracts with him which he has broken. He is manipulative and will cause trouble by splitting the staff against each other."

  [Dr S]: (Nods in agreement)

  [Me]: "Yes I agree he had the potential to split the staff, but that's exactly why we are here now, to ensure that at least the people who are involved with him will be working together. Given that we have agreed to keep him, it is important to at least minimise the chance for confusion and chaos, don't you think ?"

  [Nurse T and Dr S]: (Both agree)

  [Me]: "By the way, how has he been since being back on the ward. Have there been any problems so far?"

  [Dr S.]: (Pause) "Not that I've been aware of, he has kept a low profile."

  [Me]: "Does this seem any different from the usual day to day encounters staff have with him?"

  [Nurse T]: (Hesitantly) "Yes it possibly is, usually we would have heard from him in some dramatic fashion by now."

  [Dr S]: "Look, I think we should get on with the meeting and set some time limited for it. I don't want to spend too long with this."

- *Reflections-in-action:* "These two do not find it easy to look for new patterns and pay attention to them. S looks uncharacteristically severe and this is so unlike him to set time limits. He is usually so delightfully unhurried and thorough. I can see that this is not going to be easy and that I am going to have to monitor this whole process carefully. I

can't succeed without S's involvement as doctor, so I will have to be careful to keep him engaged. I know that T will stay in there with my encouragement but she seems rather demoralised and unable to see P's behaviour in any other light. I am going to have to spend time on this with her without disempowering her.

I have doubts about how open these two will be to hearing what P will be asking for. It will be more difficult than I thought and I will need to keep a close eye on the process of the interview so that we come out of it with some understanding of how P is seeing his current situation, together with some concrete requests to work on."

- *Dialogue:*
  [Me] : "You are right and as I am particularly bad at time keeping I would appreciate your keeping a close eye on it. How long should we give it?"

We then met with the client. He was a tall careworn man in his thirties with an east London accent, straw-like blond hair, gold-rimmed glasses and a loping gait. He wore an almost constant grin and his mannerisms were very boyish. He presented himself as someone who had reached the end of his tether and with little prompting he told a story of many years of chaotic living, drug abuse, death of close friends, loss and victimisation. He saw himself as having lost everything. Yet at the same time his boyish grin added an incongruously playful dimension and I was reminded of those same two dimensions being present during his crisis on the roof the previous day. At one point he recounted how under hypnosis he had recalled a memory of his mother attempting to smother him with a pillow as a young child.

- *Reflections-in-action*: "Hmm! I'm quite enjoying this man. There is a playfulness and ability to almost laugh at himself as he tells this dreadful tale. I feel I can work with that in some way. However, the story is starting to sound a bit rehearsed and I am not sure what I believe about memories retrieved under hypnosis, but I can readily accept this as one of the 'truths' he holds about himself. T and S are looking doubtful at this point and I can see why they have had so much trouble knowing how seriously to take P."

After hearing his story for ten or fifteen minutes I began to inquire what his more immediate problems were. He was very clear about several practical ones and what he wanted done about them. There were several of a more emotional nature to which he had no solutions. I was careful to make sure I fully understood the problems in as tangible a form as possible, then suggested we a staff group should retire for ten minutes to consider how we might meet his requests.

During our break it was easy to agree how to meet some of his more practical needs which required a doctor to look at a grazed and sprained knee, a social worker to take him back to his flat to rescue some legal papers, and some activities to keep him occupied during the remainder of his time here.

But it was less easy to agree how we would meet those emotional needs which required closer interaction with him. He had said he was bothered by repeated thoughts about his dead girlfriend and all the negative things about the past.

T talked about still feeling quite defeated by him and hurt by the criticisms he had made of the service. She felt she had tried hard to respond to him when he had made requests and then been critical of the staff for not meeting them.

- *Reflections-in-action*: "There is more evidence here that P and the staff have been locked into 'distancing - pursuing sequences' which have moved to and fro, leaving all dissatisfied. The staff have not found a way of reaching out to meet him. If they could, my guess is that they could interrupt these unhelpful sequences of interaction. I wonder if gender has something to do with this. Can it be that P is wanting a closer relationship with T as a woman and the way he goes about it is received as some form of power-over tactic? Maybe a male key-nurse would be more appropriate at this time. On the other hand I don't feel I know T well enough to broach this subject directly and she may feel undermined if I was to suggest a change of key nurse. I need to start reframing things even more and to suggest some ways of interacting with P differently.

  For me the metaphors that our conversation has suggested are 'Child-like', 'Playful', 'In the grip of his past', 'Story telling', 'Grief', 'Fear of the future'. If I could devise some reframing and activities around these metaphors which met his requests, got him involved in activities which kept him busy, and which restructured the staffs interactions so that they had regular and planned times with him at their initiation, they might have more rewarding experiences of each other and themselves. The most important task is to reframe the situation for T in such a way that it is not too far from her frame of reference but gives her a more workable and co-operative view of him."

I reframed him as 'developmentally very young' (as opposed to 'mad' or 'bad'), as someone who was 'stalled' because of his childhood experiences and his long years of drug abuse and associated chaos. If we were to understand his behaviour in this way then it would suggest certain ways of managing it and helping him. A starting point would be helping him structure his time and give him some activities such as artwork.

Secondly he was likely to be experiencing a delayed grief reaction now that he was drug free and we would provide some counselling for him to look at bereavement issues.

Thirdly, now that he was drug free it was likely he would be experiencing a good deal of anticipatory anxiety about managing the future. But at the moment he seemed to need to make sense of the past first, and perhaps we could help him with this by getting him to tell his life story and reflect on this as a preparation for entering the rehabilitation centre in several weeks.

- *Comment* on 'theory and past experience lenses' I was using at this point:

Many of my ideas and metaphors for reframing come from an appreciation of the importance of the developmental life cycle of individuals and families. Most problems can be traced to some developmental transition point which the individual, in interaction with family and wider networks, failed to negotiate in such a way that they were equipped to manage the tasks of the next stage. I do not hold that developmental transition is linear and step-like, nor is it an absolute truth as each individual and family have their own unique experience of development. However I have often found it helpful to work within and share this framing of events as one which can give problems a more normalised and less noxious or blaming meaning. It also locates the problem as being in the realm of their expertise to solve.

- *Reflections-in-action*: "T and S are looking as thought they are interested in this though T still appears apprehensive. I feel as though I have taken this as far as I can at the moment. I'll suggest we sort out which one of us takes up these tasks later. I'm worried that T may have felt that I've taken over too much and she is feeling 'one-down' in relation to P and me. I'll suggest she feed back to P what we have decided which will affirm for him that she is still in the key worker role."

T and S gave their agreement to the plan. T asked P to join us and proceeded to feedback our ideas and suggestions. However she did so without imparting much sense of encouragement or enthusiasm and the feeling of energy in the interview started to decline. I immediately regretted my haste in asking T to take on this role as I felt strongly that our reframing should be positive in both content and style if we were to fully engage P and set a new pattern of relationship going. I decided that this was more of a priority at this moment than my worry about possibly undermining T further. That would have to be dealt with on another occasion. I waited for an appropriate moment to intervene and then embellished and elaborated what T had said until I could see that P was nodding in agreement and starting to comment on what I was saying.

- *Dialogue:*

  [P]: (laughing)"Well, what do you expect, I'm Polish and Catholic".

  [Me]: (laughing)"I would expect you to feel a lot more guilty about all this." (further laughter. I ended interview).

I asked my two colleagues to quickly debrief. Again, they each acknowledged continued doubts that going along with his requests would bring about any change, but they also acknowledged they could see no other reasonable alternative. I felt surprised that they could not appreciate the metaphorical aspects of P's behaviour.

We negotiated who would carry out what roles. T did not feel she could give him the time to do his life story but was interested in sitting in with me in providing bereavement counselling. The following day I arranged for another nurse to work on his life story. He was a little uncertain

about what was expected so after some discussion I suggested some ways of doing this with the promise I would review progress regularly with him.

By the time I was able to see P for bereavement counselling several days later, he had already started his life story and was so engrossed with this that he felt he did not need help with grief or bothersome thoughts about his dead girlfriend.

Over the following several weeks there was no further occurrence of his bizarre or demanding behaviour and he was able to sort out his affairs sufficiently to feel he could move on to the residential rehabilitation centre. I spent little time with him apart from brief reviews. I saw T on four or five occasions and discussed some of my ideas behind what I had initiated, mostly focusing on reframing and helping her retain the 'developmentally young' frame and ways of managing P's stay within this. I shared some ways of preventing tantrum behaviour which I had learned from working with children and families (including my own).

I saw my main task as holding the 'frame' firmly enough to guide my own and other staff's actions until we had experienced it for long enough to see what the outcome was. I did this by being available for consultation, by being around the decision-making points (both formal and informal) and by asking questions in such a way as to elicit any evidence for new patterns of relationship developing which might suggest certain solutions as being more worthy of attention than others. These could then be used to inform further action.

- *Comments* on 'theory and past experience lenses' I was using at this point:
  The concept of 'Brief Therapy as Aikido' is useful in making an intervention in situations such as these. Simply put, after circling around and testing your opponents balance, and finding a point at which you sense that an unexpected move may unbalance, then the important thing to do is to complete the move through without hesitating until it is clear whether or not the move has succeeded.

  However, I am uncomfortable with constructing others as opponents although the metaphor captures something of the essence of balance/unbalance/new balance in crisis work. More recently I have become attracted to notions of 'participation' and 'co-evolution of new realities' as another map for what occurs in therapeutic interactions.

In the meantime, P remained a colourful character and continued to strain the staff's belief in his credibility. At one point he declared his engagement to be married to an anorexic young woman in a neighbouring ward. But, he completed his stay successfully and left in a more timely way to transfer to a longer term rehabilitation centre. He was free of drugs and alcohol for the first time in his adult life, had tidied his affairs in his home town, and was ready to 'move on' with more confidence.

On leaving he thanked me for "cushioning" him during the second part of his stay and I was struck by the connection between this metaphor and his threatening to throw himself off the

roof. I wondered if I might have been successful after all in helping colleagues see him differently. Several days later, a casual conversation in the ward office:

- *Dialogue:*
  [Me]: "We seemed to do OK with P don't you think? He quietened down a bit and even seemed to have made a few changes."

  [Another Ms. Junior Nurse]: "Yes, but he's still full of shit!"

As I finish this story by noting some final reflections, I am surprised by my surprise at colleagues not being able to share my frameworks. I came to this case by a very different pathway and considerably more experience. Most of the people I interacted with during the case have only recently come from, or are still within, mainstream education.

I am also interested in how much I had failed to apply my beliefs about developmental life cycles to all the actors in this drama. My reframing of P as if he were childlike constructed him as requiring parenting and us as staff as providing this. I did not consciously consider the impact of this for T as a young woman who I later learnt was struggling with the dilemma of simultaneously developing a relationship with the man she lived with while at the same time individuating from a very close relationship with a divorced mother who was ill and needing support.

In reflecting back on this and other similar cases, together with the changes which have occurred in the department, I see that one of my roles has been producing stability and change for the client in harmony with other changes. One of the questions which arises for my practice is how to maintain the balance between the needs of myself and colleagues for growth and change, and those of clients for growth and change.

End of story.

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Making sense of the story

So, what did I take from this story and the writing of it? It had felt difficult to engage others in the sort of decision making and reflection about the case I was interested in. Despite the success we had achieved in the short term with the client, I realised there was much work to be done in supporting colleagues in handling such cases more successfully and changing our patterns of relationship around case work.

However, there seemed potential to join more with William in developing a working relationship around these sort of cases as a focus. He showed flexibility and humour and was willing to consider alternative viewpoints. There was also potential to work more with junior nursing staff. Shortly after this case, T asked me to help her with several more cases where she was struggling with the considerable complexity she was encountering. I was seeing now, at first

hand, how junior staff were often left unsupervised and unsupported with work beyond their skills and experience. The matching of skills and resources with need was a haphazard process.

This story alerted me to how I had probably cut across the prevailing culture in advocating for the client to be readmitted to the ward. This could be a partial explanation for the degree of energy it required for me to facilitate a new care plan and 'make it stick'. However, it was also satisfying to do this and see a more productive outcome. I saw the potential to develop this role in working with the more complex cases - it harnessed my skills and interests, and it seemed it could be one focus or fulcrum around which change could occur. Correspondingly, this also seemed an engaging and interesting focus for research.

In thinking about the criteria for rigour I had laid out for myself, one factor considerably occupied the foreground, obscuring the others - that of authentic collaboration with others in the research field. I was still seeing research as separate from practice, as a bounded field of activity under the banner 'this is research' which was 'about practice' and 'on practice, not 'in-practice'. This cognitive dissonance generated anxiety for me which I resolved at that stage by deciding the only way forward was to attempt a Cooperative Inquiry. I was unable to see the analogue communications which were suggesting that collaboration in that particular form was an unlikely prospect in the current climate. ..I was construing collaboration within research as being characterised by all participants opting in to a research project, fully informed and fully in agreement. This would be the only way we could together 'map the territory' and fully inquire into our individual and collective sense making. Anything short of that could not be collaboration. This construct also blinded me to the degrees of collaboration which <u>had</u> occurred in the story. There would have been no story, or a different story, without a degree of mutual collaboration.

The writing of this story surfaced for me how many frames, skills, theories and experiences I had available to me at any one time - more than I had previously been aware of. This awareness compounded my dissonance about research. If I was to explore these and share these with others, as I intended to do in research, then how could this possibly happen in moment to moment engagement. It could only be done in the bounded setting of a group set up for that purpose. On the other hand, I felt unaccountably vulnerable and exposed at the idea of sharing this sense making. It was all very well to feel legitimised by Heron's epistemology, that experiential knowing is 'OK', but it was a very different matter offering this to colleagues who seemed to see the world very differently.

In terms of Rowan's research cycle, I was not sure where I was. In overall terms, I saw myself as preparing to move from *thinking* to *project*, taking a risk in involving others. Yet in an obscure sense it felt as if I had done this already in practice. Taking on this case had involved project, encounter and making sense. Was this what Rowan meant by small cycles within

larger cycles? This, however, was background. I told myself that all this would be of more significance when the 'research proper' started.

I was also interested to discover through writing how much I was influenced by the more structural and strategic aspects of family systems therapy as providing frameworks for action with colleagues around case work. The systemic epistemology of Cronen and Pearce links with a series of practice frameworks which involves a stance of 'neutrality' towards inquiry. This is not a neutrality of values, but a neutrality towards the particular form of resolution a system finds for its dilemmas. This is transacted through a series of carefully selected questions with the aim of establishing patterns connecting belief, behaviour and relationships with the presenting problems and dilemmas. It does not lend itself to the sort of reflection-in-action related in the story. Even in the writing, it was difficult to apply this. As I wrote, I was aware of so many contexts informing the action, from the past and the present.

The sum effect of these reflections was that I needed to form a Cooperative Inquiry. I now felt I had a focus with 'bite' and interest , one with which I felt congruent. It was also a focus which could involve clients in the inquiry process. I needed to overcome my apprehension and doubts and set up a project .

Starting a Cooperative Inquiry group, and losing my way.

I will describe some of the steps I took and the eventual outcome. In doing so I will not be writing in as much detail as I would like in order to do justice to the experience. It did not lead to a fruitful outcome in itself, although it created a context for further development. I will tell of my experiences briefly and from this perspective.

Despite seeing this as the way forward with research, in fact I became increasingly busy developing various roles in the department. There was much to be done which required my time and energy and I continued to keep a 'noticing' eye on my practice. I was not sure I could either find sufficient colleagues within my immediate department to join me, or whether there was sufficient 'space' among all the changes and developments. Through continued reading and discussion at Bath, I realised that I wanted to select people for the group who had some interest and willingness in joining and who could provide the different professional perspectives I was looking for. I thought I might need to canvas wider than the department.

I then spent several months preparing a research project to inquire into the management of "Difficult Cases". I wrote proposals outlining my interest in this as both a researcher doing a PhD and as a practitioner working on a day to day basis. I outlined the basic theoretical ideas I would be using, the implications for those who wished to participate, and the hoped for outcomes in terms of improvements in clinical practices, local knowledge, and improved patient/client participation in treatment planning. I was uneasy about the term 'difficult cases' as it appeared blaming of clients, but I decided that it was a term which was in current implicit use and would have immediate meaning for staff members. However, in my proposal I was careful to deal with this by proposing an initial broad definition as applying not to individuals,

but to the situation we often found ourselves having to deal with, namely both the client and professional networks seeing themselves as having reached the limit of their resources and therefore presenting in crisis.

I talked to various stakeholders in the organisation whose support I believed I would need. These included the Chief Executive and my professional head the District Psychologist. I set up initial meetings to present and discuss the proposal and invited colleagues from not only my immediate department but across the wider Mental Health Unit. I decided I would invite those within my department I believed would both have an interest and also represent different disciplines. These included William and my wife Jan who was engaging in her own research with nurses. In her role of manager Jan had developed a close working relationship with William and had introduced him to some of Torbert's work. We were able to have conversations together about his ideas.

My invitation across the wider unit was to heads of departments or team leaders, asking them to inform those colleagues who had an interest in this area. My intentions were twofold. I needed a wider and more heterogeneous group representing the multiple professional viewpoints than I could obtain within my immediate department. Also, there was an explicit interest across the mental health unit in dealing with the most demanding clinical problems. Nurses were researching "challenging behaviour" in some client groups and there were discussions abroad about a new Intensive Care service for extremely disturbed patients who required more intensive nursing than could be provided in existing acute admission wards.

It therefore seemed timely and relevant to involve colleagues outside my immediate department. There seemed to be a fit between my research interests and wider concerns and I could also get a more heterogeneous group representing the differing professional perspectives. I sensed that some among them would have a more active interest than immediate colleagues.

I held an initial meeting to test this out. Over a dozen people attended, mostly nurses, several psychologists, plus Jan and William. Over the course of two hours we covered both theoretical and practical implications of a research project. I also presented my own beliefs and assumptions and told several stories about past experiences to illustrate and provide a grounding for my interest in this area. I also wanted to convey in practice some of the attention to personal process required in this way of doing research. I wanted to keep a balance between providing enough information for people to make a decision about whether this approach was 'for them', but leave sufficient openness for potential participants to feel they could take part as co-researchers in defining the project themselves.

There was a range of responses. Some saw the project as addressing "challenging behaviour" which transpired to mean dealing with aggressive and violent behaviour from men. Others seemed mystified. Some responded to the theoretical areas, several responded to my stories with similar stories. One woman expressed concern at the limited focus on challenging

behaviour and told of how she found if far more difficult to deal with female clients who developed long-term dependent relationships which left her feeling drained and defeated.

My psychologist colleagues saw this research approach as a variant of their own and expressed no interest in joining. This was revealing to me as I had not known previously of their interest in qualitative research and despite their lack of interest I felt I had developed a new connection with them.

The meeting ended with several participants saying they would like to 'hear more' from me. Only one person after the meeting approached me with what seemed genuine commitment. A senior and very experienced nurse said after the meeting that he understood little about the research side of things but would very pleased to join me. For me this was the most affirming response of the afternoon. (I was to link up with him several years later in developing the new Intensive Care service).

I was left with the following impressions:

- The participants worked very separately from each other with separate working practices.
- There were very diverse interests within the group, mirroring the diverse interests apparent across the mental health unit. Implicit in this was a degree of conflict which would be difficult to resolve within the context of a research group. I could see little evidence from the meeting that there was a sufficient degree of commitment, shared goals, and openness needed for a group to learn to work cooperatively together
- I was left with one concrete offer and several expressions of interest from outside my department.
- I had a 'gut feeling' that if I were to try to take process to the next stage of forming a group of six to eight members I would not have the time or resources as the initiating researcher to support a range of inquiry across different settings.

I was left feeling doubtful and unsure of where to go from here. On the one hand I could intellectually appreciate a systemic view that 'all information is relevant' and 'if the feedback does not confirm your hypothesis, then change the hypothesis rather than ignore the feedback'. On the other hand, as a researcher, how could I take the research forward if I could not see a way of achieving open and authentic collaboration, with the field of inquiry being defined through a process of consensus agreement. Events were not fitting my vision of how the research should be and I was unable to change my views about research to fit the events.

On a personal level, I was carrying the familiar sense of vulnerability about the degree to which I would be able to create a climate in which I could reveal how I conceptualised my work. I did not understand that vulnerability well and did not feel inclined to pursue it as it felt too painful. This examination only happened at a later stage when in crisis over the research.

My understanding at the time was that my sense of integrity was at stake. Part of this sense of integrity involved managing a contradiction between, on the one hand, a willingness to disclose according to the degree to which I felt others would be interested, versus on the other hand, a recognition from experience that disclosing viewpoints which differed too markedly from the prevailing culture risked marginalisation. I felt I could not afford to become marginalised through this process if I was to achieve my hopes and ambitions to be centrally involved in participating in change towards a more alive, open and flexible service.

From this point I could see no way of managing the inherent difficulties as I saw them in starting a Cooperative Inquiry. My plans were shelved for a prolonged period while I immersed myself in my practice. This decision inadvertently lead to the gradual emergence of the second strand of my research to which I will now turn, where practice and research become more intertwined. The next chapter sets the scene for this.

7. PREPARATION FOR ACTION INQUIRY

Introduction

Having set aside the idea of a Cooperative Inquiry group for the time being, I immersed myself in practice. By now there had been many developments in the department and I was working across a number of different teams, supporting the changes. I was still keeping a 'noticing eye' on my practice, capturing experiences in notes and journals as I went. However I was feeling rather dispirited as a researcher, wondering how I would ever get started. I was doing increasing amounts of work around 'difficult' or 'complex cases' but I still felt wary about having explicit conversations about what I was doing and what I was trying to achieve. Nonetheless, in preparation for 'the real research' I began considering how I might test out in practice the relevance of some of the concepts from Torbert's Action Science.

By way of providing a background for this 'testing out' I want to develop two strands in this chapter. The first is to describe changes in the department in terms of the services provided, the roles played by different members, and the relationships between them. This 'thick description' will provide a set of context's for construction of meaning about the events I wish to describe in subsequent chapters. In terms of Cronen and Pearce's (1986) set of embedded levels of contexts for construing meaning, I will be describing some of the patterns at the level of *relationship* and at the level of *cultural beliefs* (including professional and organisational) which I discerned to be operating at the time.

The second strand in this chapter is my further reading of Torbert's model of an Action Inquiry. He uses the terms Action Inquiry, Living Inquiry, Community of Inquiry, and Collaborative Inquiry, in a somewhat interchangeable way across his writings, according to his particular focus. I will stay with Action Inquiry as a broad term to cover his work will present several aspects which seemed to offer potential rigour to an inquiry into my own practice.

As a narrative comment, these two strands are contiguous not only in terms of framing the next stage of my research journey, but also because they signal the emergence of power as an issue in relationships. In the account which follows, based on diaries and records written at the time, I describe how I saw power as operating in practice. At that time I was standing outside these descriptions, unaware of my own implicit framings and unaware that I was seeing power in terms of an attribute which individuals possess. From my reading at that time of Torbert's (1991) model of power at the heart of his Action Inquiry, I saw myself as having only limited forms of power and hence 'side-stepped' it as having only limited potential relevance.

I will revisit power much later in this thesis, describing how, toward the end of the research journey, I developed a more multi-dimensional view which was more thoroughly grounded in personal experience. It was only at this later stage I came to realise more consciously that I was seeing the consultants as 'having' power and myself as being 'power-less' in relation to them. In the meantime, this chapter contains the seeds of that later awareness.

This chapter has two parts;

- an account of further developments in the work setting;
- further readings from Torbert's Action Inquiry model.

Further developments in the work setting.

By this time, the department had reorganised into a completely different format from when I had first arrived. This had been based on a department-wide consultative and planning process which Jan had led shortly after her arrival. We had broadened our remit to include all forms of addictive behaviours, although substance misuse of one form or another was still the main presenting problem. We now had a community team, coordinated by the most senior clinical nurse, which comprised community psychiatric nurses and counsellors who worked in different localities alongside other community services. This was backed up by a range of hospital based services, including in-patient assessment, inpatient detoxification, and various day-time psychological treatment and support activities. Augmenting both community and in-patient services was an outpatient service (providing assessment, consultation and follow-up treatments) delivered from the hospital site and provided by doctors, nurses, psychologists, occupational therapists and social workers. The most senior and experienced staff were based in this setting because it was both a local service to the health district as well as a regional and national specialist service.

I saw the patterns of working together across the department and between the disciplines as being strongly influenced by the interests of, the roles played by, and the relationship between the two consultants. At that time I felt that any initiatives I took would have to be in relation to the consultants as they expected to take lead roles in determining the direction and nature of services delivered. I saw the issue for me as finding a relationship with each respectively in which there was mutual recognition and support, therefore I needed to understand how they worked, what they hoped to achieve, and where they were 'coming from'. These were the lenses through which I observed relationships in the department at that time.

Working together - cooperation and conflict..

By now all staff were conversant with working with both alcohol and drug problems, apart from the two consultant psychiatrists who retained their separate interests. Stewart had a strong interest in illicit drug misuse and had obtained public health funding to do HIV/AIDS prevention work. This occurred mainly through the provision of legal prescribing of substitute opiates to minimise risk and reduce harm associated with the injection of illicit drugs and the chaotic and criminal lifestyle which surrounded their use. Stewart took on consultant psychiatrist responsibility for those clients seen by the community team and those admitted to hospital requiring drug detoxification and management of drug problems.

William, on the other hand, took consultant psychiatrist responsibility for the hospital based services and for those clients across the service who had alcohol and related problems.

However, the way in which they had divided their work created tensions for themselves and others, most of which remained implicit. For example, although William had consultant responsibility for patients in the hospital based services, Stewart exercised complete autonomy over services to drug patients. Gradually, the available resources became increasingly used to meet the needs of drug users and William appeared to allow this to happen. Also, although the community team saw individuals with alcohol problems, it was Stewart who provided medical consultation to them on this area. Team members commented privately that Stewart seemed less interested in these problems and as a result they took second place in team case reviews.

The implications of this were that when there were conflicts of interest arising out of meeting the needs of drug versus alcohol patients, in both the hospital and the community settings, resolution was difficult to achieve because of the unacknowledged differences between the two consultants.

My reading of this was that there were two factors at work. Firstly, the professional socialisation of doctors deeply ingrained a belief that a consultant could practice with complete autonomy, no one had the right to tell him or her what to do (It was widely held within health circles that the central government reforms of the 1980s were intended to interrupt this state of affairs). Secondly, Stewart was a strong advocate for the role of substitute prescribing as a means of changing patterns of drug misuse. He believed that drug use was endemic in our society and that many of the accompanying problems were caused by its illicit nature, placing the selling of drugs into the hands of international crime with the subsequent exploitation of drug users, forcing them to use adulterated substances with risk to health and forcing them into crime to pay exorbitantly inflated prices.

On the other hand, William was deeply against prescribing on moral grounds and was adamant that he did not want to prescribe "free drugs". Nor did he wish to enter into the sort of co-dependence with drug users which came with prescribing, often for years on end. However, he accepted that it was reasonable for this sort of service to be provided because of its ability to prevent spread of HIV. This difference was not discussed in public by the two, but I knew that if William were to challenge Stewart about his transgressing the boundaries, Stewart would challenge back about William taking on some of the prescribing load. The two retained a cooperative working relationship by joining together around mutual interests as consultants, such as pay and working conditions, teaching of medical students and junior doctors, and their responsibilities for doing the after hours 'on-call' rota for responding to emergencies within the wider Trust. Complaining about central management by the Trust executive group was an additional 'shared reality'.

However, over time I came to see their relationship in a slightly different light, in relation to more subtle issues arising out of the widely accepted 'medical world view'. This world view afforded both power and vulnerability. Each consultant had their basis of professional authority and

identity within medicine. Neither consultant wished to work in mainstream psychiatry for a variety of reasons, but both had an interest in psychological treatments and so working in addictive behaviours provided a solution to this dilemma. However, they had received only a limited training in psychological methods and had only limited expertise in psychological treatments. So they drew their power and authority from within medicine with its emphasis on the primacy of the doctor's medico-legal responsibilities, on diagnosis, and on treatments which clearly and logically followed from this diagnosis. However, this 'medical model' does not map easily onto the complexity of problems with mental health and illness. Diagnoses do not provide a neat description of the aetiology and course of the 'illness', and nor do they provide accurate predictions about treatments or prognoses. Nonetheless, the model still holds primacy, both within health circles and by the public at large.

If the consultants were to step out of this territory, then they would lose a substantial amount of their influence when working alongside other professionals who were at least as skilled, if not more so, in the various competencies required to deal with mental health and illness problems. They each required the other for affirmation and support in their roles as doctors, and therefore would turn to the other for this in times of uncertainty, risk or conflict. This provided a position which afforded safety and certainty and maintained their power, but it was also a position which did not support change and transformation as it kept them firmly within a positivist world view. It also located them in continued reliance on Argyris and Schön's (1974) Mystery-Mastery strategy. The reliance on this strategy is not unique to doctors and is one I observed from time to time within psychology, although with a different texture due to a different power base.

A further factor establishing doctor's centrality in mental healthcare is their statutory role to sanction admissions and discharges from hospitals, to detain patients under the Mental Health Act, and to prescribe medical interventions such as medications and some physical therapies such as electro-convulsive therapy. Nurses similarly are required by law to provide healthcare to patients in hospital setting. By contrast, Psychologists and other 'Professions Allied to Medicine' have no such statutory roles and mental health services are not under a statutory obligation to employ them, although it is recognised in codes of practice that services should be multi-disciplinary.

This was my understanding at the time of the roles the two consultants played in the department and of how I saw these roles being maintained by both power and vulnerability. I located myself outside such an analysis. Implicit in it is a construction of them as 'having' considerable power to set the agendas and determine the pattern of service delivery, and of myself being relatively 'power-less'. This was a construction which was to 'shadow' me for some time to come,

I have already alluded to the introduction of substitute prescribing as having considerable influence on patterns of service delivery and relationships among the 'actors', but I would like

to elaborate on the nature of this influence because it is a significant fulcrum around which differences in viewpoint, and hence conflict, occurred.

Substitute prescribing - a 'double-edged sword'.

Most of the original drugs team (Nurses and Counsellors) welcomed the arrival of substitute prescribing with Stewart because they felt they had not been able to attract drug users to the service without it. On the other hand it was an activity which had come to take centre stage in most of the interactions between staff and clients, and between those staff who worked in this part of the service and Stewart.

Stewart saw prescribing as the "lever for change" with drug using clients, using it to attract them to the service then using it to both meet their immediate needs while at the same time requesting change in behaviour and attitude in return for its continuation. In the early days he described it as a "bargaining tool". However, there was a 'flip-side' to this which meant the health worker was now tied to the client in responsibility for maintaining the supply of a powerfully addictive substance. Many drug using clients frequently presented in crisis, unable to adjust to the routine and limitations introduced into their lives by being on a script - for example, regularly collecting it from the pharmacist, attending weekly appointments for counselling and review sessions, and so on. When the client was in crisis because they had prematurely used their script, or lost it, or for many other reasons were not coping, then there was a high degree of urgency for the worker to respond. Drug using clients could place severe pressure on services to respond immediately with complaints, threats of violence and actual violence. This placed all in a tightly bound relationship with its many frustrations.

By initiating this service, Stewart had unfolded a far bigger pocket of hidden need among the population than anyone, including himself, had imagined. He could not see everyone and had insisted that every client on a script had a drugs counsellor (a role played by a range of staff) who had to take responsibility for assessing and meeting their needs This included the week-by-week negotiations for any changes or reductions in scripts as they supported the clients in reducing their drug use and in making changes in their lives. This could work well or badly according to the stage of motivation the client had for really making change. This arrangement placed Stewart or his junior doctors in a particular hierarchical situation in relation to both client and other staff and he had not organised this in a way which made it easy to manage. The onus was on the drugs counsellor to find Stewart or one of his junior doctors and provide them with all the relevant details. This lead to much frustration and stress for all.

It had been agreed at the outset of my job that I would provide some support to Stewart in developing the drugs side of the service. I did this through being part of an assessment team seeing drug clients for the initial assessment and making decisions about how their needs could best be met within the resources across our services, including being placed on substitute prescriptions. I had not worked in a service which offered prescribing for drug users before and was interested to learn what the issues were.

However, having done this for some time, I had decided by now it was not the best use of my skills to spend time with clients who, for the most part, did not particularly want to learn alternative ways of managing psychological stress or distress at this stage of their drug using careers. This did not discount their need for such a service, it was more that my skills were better placed at other contact points. In addition, I did not enjoy being placed in such a powerless position, trying to meet client needs by pursuing doctors across busy timetables for scripts. It was gradually becoming clear to me that I would be more effective if I only took on directly those cases where there was an agreed need for specialist psychological interventions.

I had tentatively tried to raise these issues for discussion but did not feel my immediate nursing colleagues at that time wanted to confront the issue. It seemed they saw their power base as coming from the interdependent and delegated role relationships with a doctor. I had one or two confrontations with Stewart but these did not lead to any meaningful discussions where there was mutual listening. I needed Stewart's support if I was to work effectively with drug users, and he needed me because ultimately, as he often put it, "despite all the pharmacology involved, at the end of the day it is all about psychology" However, we had different ideas about the nature of that psychology.

It was clear to me that the roles the doctors played were a major factor influencing the degree of flexibility required for adaptation and change. I saw myself as having to negotiate my way between and around the implicit and explicit differences and conflicts of interest, while at the same time maintaining my sense of personal authenticity and hopes for an open, relevant and alive service. I felt that I needed to develop a more collaborative relationship with them in those areas of my work where there was a necessary interdependence. I saw possibilities for this within my relationship with William but was unsure of how to achieve this with Stewart. In the next chapter I describe my practice with two 'complex cases' in which I attempt different ways of working in relation to Stewart around the focus of casework. But before moving on, I wish to give a more expanded description of the roles I had developed within the department and of the network of relationships of which I was a part. Again, this is with the intent of creating a backdrop for understanding developments in the research.

My roles within the department.

I was responsible for the small psychology budget and had now employed a junior psychologist to support the community team and together we had two-tenths of a secretary. My job was to provide specialist psychological treatments to the department within these resources and to provide teaching and supervision to psychologists in training. While I was seen by others as taking the lead in the psychological treatment area, I did not want to do so in the traditional way which would have placed me outside other arenas. I ran the risk of giving up a degree of formal power over psychological treatments for wider and less easily understood roles because they afforded the opportunity for participating in wider change in how services were given.

This was another 'double-edged sword' as I saw it. Claiming sovereignty over psychological treatments, as had other psychologist colleagues in the Trust, would place me in an overt position of being in charge of a certain range of activities. On the other hand it would also place me into conflict over territory, particularly with the two consultants who saw themselves as having the expertise to assess for and prescribe a range of treatments, including psychological. Rather than remaining located purely within the role of providing formal 'psychological treatments', I chose instead to occupy a range of roles which allowed me to work more flexibly in supporting others in developing their psychological skills and knowledge, and at the same time facilitate the delivery of quality health care.

I was happy for others to take up psychological treatment roles and to support them in this, even if they did not closely follow prescribed methods. I was careful to ensure they operated within their competencies, skills and responsibilities, and sought to complement what they were doing rather than prescribe how things should be done. I would take on cases only after consultation and being sure that my skills were needed. Accordingly, I only took those cases which were complex or required a degree of specialist skill or expertise not able to be provided by other team members. Carrying a caseload myself and supporting others in carrying theirs was my base within the department.

Taking on a range of roles enabled me to understand the organisation from a number of vantage points. As a member of the Core group I developed an understanding of the strategic development issues we faced. These spanned service agreements with Health Authorities across the region, relationships with other departments in the Mental Health Unit and with other agencies in the district, and the internal administrative procedures and resources required to support staff in fulfilling their roles. The Core group was not so much a forum in which decisions were made, rather it was a place in which ideas, stresses and tensions were aired in various forms.

I had also taken particular responsibility for ensuring the smooth running of outpatient clinics so learned first hand about the views of secretarial and administrative staff and how the department appeared through their 'eyes'. I learned that the conflicts and difficulties which arose from time to time mirrored the differences between the consultants. This had to be worked around to ensure the clinics functioned effectively.

Through my clinical work, I was developing a closer working relationship with several nurses as well as the Ward Manager on the inpatient ward. This enabled me to understand what their day to day work was like and what the issues were that they faced. The Ward Manager saw me as someone who could support her and had asked me to work with the nurses as a group on several occasions in helping them audit aspects of their work, and in dealing with clinical problems. Two of the nursing team had started consulting me about their case work.

Through providing supervision to the junior psychologist and several community team members, I had access to their experiences in both providing community based services and in

referring in their clients for hospital based care and treatment. I was able to provide for them the alternative view of what the hospital-based services were trying to achieve and what the overall direction was which we as a department were trying to take. Several members of the community team had worked for many years in the old hospital based service and tended to construct a 'them and us' view and I found myself providing a mediating viewpoint and on occasions a very challenging viewpoint when I felt some of their criticisms of the service were demeaning of the efforts others were making. Within the department, my roles 'bridged' many different sub-systems and I was later to realise how this afforded my much influence in facilitating change.

For the time being I did not see this as a form of power, in fact I often felt isolated by occupying this multiplicity of roles because few were able to understand what it was I was trying to achieve. Fortunately, I was able to find a small network of people in the wider health care system who had similar ideas. Within the department, Jan and I had a partnership in ideas as well as being a couple and were able to work together in supporting each other and I will weave this as a strand into the research from time to time.

Relationships between the department and the 'wider world'.

Finally, as part of a wider mental health organisation we were going through the phase of developing service agreements with the health authority and preparing for Trust status. This meant that we were to become a "self-managed" legal entity as a healthcare provider which would enter into contractual agreements with purchasing Health Authorities. It was becoming clear that we were not going to generate enough income from our existing purchasers (which include several other surrounding health districts) and we were about to develop a marketing strategy. In preparation for this Jan, in her role as Directorate Business Manager, had found funding to extend and refurbish our buildings, increasing our bed numbers and giving us more options for developing services.

The process of developing a marketing strategy was to eventually change the way our department worked with outlying districts who referred in to us, highlighting differences in attitudes within the department and giving rise to more explicit conflict. This creates a setting in which I revisit the issue of power later in the research.

In the meantime this is the backdrop against which I focused more on practice, setting aside for the moment the idea of Cooperative Inquiry, and instead exploring alternative possibilities from within Action Inquiry. In preparation for reporting this in the next chapter I will now present those aspects of Action Inquiry which seemed most salient to my practice at the time.

Further readings from Action Inquiry.

Although Torbert (1981) warned that Collaborative Inquiry was an experiential process, occurring in a more or less distorted and incomplete fashion at any given moment, I was still unable to fully appreciate its relevance to me at this point. I was unaware of how much I was

in the grip of certain old paradigm notions of research, most particularly, 'once you have chosen your focus and your method, stay with it despite inconvenient interruptions'.

However, I had been reading more of him and Jan had introduced his work 'Power of Balance' (Torbert, 1991) to William, the clinical director. The three of us from time to time referred to some of his ideas. At this point more of his ideas were seeping from the background to the foreground of my awareness as usefully informing my practice. The ones I will present here are:

- his operationalising of the interpenetrating attention span at the level of interpersonal dialogue;
- his development of various concepts of power to form a liberating and transformative 'Power of Balance';
- the associated developmental model of leadership which is required in order to exercise a power of balance.

An interpenetrating attention span.

Torbert (1992) operationalises the concept of an interpenetrating attention span (embracing the four territories of experience of purpose, strategy, behaviour and outcomes), for use in dialogue at the level of individual practice. Purpose, strategy, behaviour and outcome are translated into the terms 'framing, advocating, illustrating and inquiring' respectively. His premise is that if even one, two or three individuals in an organisation practice quality improvement with regard to their own actions, the organisations effectiveness can improve. "If the organisation's leaders are sufficiently artful devils, widespread, committed, inquiring participation may be the eventual outcome but it is scarcely the starting point" (p5).

- *Framing* refers to the speaker explicitly stating what the purpose is for the present occasion, what the speaker thinks the dilemma is which requires resolving, and what assumptions the speaker thinks are shared or not shared. The speaker can either suggest a frame for resolving a dilemma, or invite a surfacing of frames which others are bringing into the situation in order to minimise confusion of purposes. The aim here is to increase one's own and others' awareness of a shared question, vision, or mission.
- *Advocating* refers to explicitly asserting an opinion, perception, feeling or proposal for action. Torbert maintains that typically such assertions are expressed in terms of action but seldom in terms of feeling. Alternatively, he proposes an early and "vulnerable description" of feeling to minimise defensiveness and to invite openness from others. The aim is to increase mutuality and internal commitment among the actors or participants.
- *Illustrating* involves telling a concrete story to "put meat on the bones" of advocacy with the intention of orienting and motivating others. It also gives clear implications for action,

or directionality, which advocacy alone may not give. The aim is to highlight incongruities or lack of alignment between individual, group and corporate objectives, actions and effects.

- *Inquiring* involves questioning others in order to learn from them about their perceptions of what has been framed, advocated and illustrated. The aim is to engage in a verbal form of action experiment which seeks to realign objectives, actions and effects across individual, group and corporate levels.

Torbert characterises this interpersonal strategy through dialogue as 'gently assertive inquiry' in which the actors pay more explicit attention to the dialogical nature of experience. The achievement of a balanced integration of these four kinds of speaking is not oriented toward attaining preconceived outcomes, but rather toward increasingly high quality awareness and genuinely informed action at individual, group and corporate levels. It is through this process that he believes effective outcomes become more likely. I was not sure about how smoothly this would translate into practice, but it would be one way of moving towards more explicit inquiry and hence address in part the concerns I had about authenticity as a researcher.

The particular appeal which the concept of an interpenetrating attention span held for me was its systemic quality of linking 'internal' elements of experience of the individual with outcomes or feedback from the 'external' world. It also offered a map for making sense of feedback loops between self and groups, and between groups and larger organisations. It held some analogic connections to Bateson's (1979) concept of mind as 'the pattern which connects'. Bateson conceptualised 'mind' as extending beyond the level of intrapersonal cognition and awareness to include all the elements within the field of awareness and the information feedback loops connecting all the elements. In the example of an individual chopping firewood, Bateson poses the idea that mind includes the person in action, the axe and the wood - the person swings the axe at a different angle according to the changing shape of the cut, and the cut changes shape in accordance with each swing of the axe. This set of information loops occurs in a wider context of information loops, all potentially connected in a non-linear fashion, according to whichever 'punctuation' the observer makes.

In Bateson's concept of mind he poses the conundrum of whether purpose exists, in the sense that no one element of a system has control over the others or in any way is causal. Any event, in a cybernetic model of events, is both cause and effect. The concept of purpose implies a sense of 'causality', as if a chain of events emanates from some purpose. Torbert's main framing of the interpenetrating attention span can all too easily suggest a punctuation whereby 'purpose' has a particular power as a causal factor. I was grappling with this at an experiential level. Purpose often seemed to occur at multiple levels across time, frequently unravelling the more I questioned it, and often seeming to emerge out of action. To illustrate, I will recount an experience at a conference.

During an experiential stream between workshops, a group of us went through a series of Tai Chi exercises with an instructor, one of which was called 'Sticking'. It involved one of a pair being a follower and the other a leader. The pair started with establishing hand to hand contact with hand outstretched and palm down, the follower's hand on top of the leader's with just the necessary degree of pressure to achieve a contact which was that of touch without weight. The leader then led the follower, whose eyes were closed, in a series of spontaneous movements, but in such a way that the lightness of hand contact was maintained. Then the roles were reversed. During de-briefing each of us in the pair discovered that we had shared the experience of rapidly losing sense of who was following and who was leading. There seemed to me to be different levels of purpose for and during the exercise, the highest level seeming to be the creation of a dance of participation in which the dancers lost sense of themselves and became aware of only the dance. This was not apparent before the exercise. Was this purpose, effect, or both?

Torbert's more recent writings addressed the wider context in which Collaborative Inquiry could be practised. This is presented next and I take ideas from that which spoke to my research at that time.

Power of Balance.

In his work entitled 'Power of Balance' (1991), Torbert advocates that we need a theory and practice of a *liberating structure* - a theory of power, a practice of management, and a method of inquiry that integrate freedom and order, empowerment and discipline, inquiry and productivity, transformation and stability.

He proposes that leaders in various areas of enterprise can and must exercise an inherently positive kind of power in order to succeed in generating and sustaining organisations that are empowering, productive and legitimate, and appropriately manage change in turbulent environments. He calls this type of power *'The Power of Balance'* , comprising a dynamic blending of four constituent types of power; unilateral power, diplomatic power, logistical power and transforming power. He proposes that when transformative types of leadership are linked with Action Inquiry within this paradigm of power and justice, then liberating structures can be created.

It was his analysis of power which captured my attention as being relevant to the early stages of my research. I saw power as something which would almost certainly crop up in any inquiry into teamwork with differing disciplines which had differing world views and degrees of authority. However, the development of a liberating structure, linking Action Inquiry together with differing types of transformative leadership, seemed out of reach to me initially. I saw it at the time as requiring formal authority in an organisation which lent unilateral power, the necessary ingredient for creating the conditions for more liberating structures.

The key aspects of the four different types of power which stood out as seeming relevant for my initial purposes were as follows.

• *Unilateral Power.*

Defined as the ability to unilaterally and uni-directionally cause the outcome one wishes, unilateral power is the most frequently used modern conceptualisation of power. Torbert dates its development from Hobbes in the seventeenth century and traces its presence in social, political and economic theory and social organisation since that time. In its most basic form, Hobbes saw it as the physical power to kill. He reasoned that it was the fear of death that motivated people to yield their individual power to a sovereign who could then use the much greater collective power to secure an order which, no matter how uncomfortable, protected people from the "war of all against all". Within this conceptualisation, the sovereign must have supreme power because any sharing of power allows for division and struggle for power which he is seeking to prevent in the first place.

The ethical theory which most closely matches unilateral power is the Utilitarian ethic of the 'just decision' which procures the greatest good for the greatest number of people. It maximises pleasure and minimises pain, that is, maximises utility. This perspective, Torbert notes, implicitly requires either an omniscient rational sovereign, or a kind of rationality in both individuals and society which calculates how to prioritise desires to achieve the greatest good for the greatest number. He argues that there is no mechanism available in this construction of power to regulate or mediate conflict between competing frames of 'what is good' according to membership of different groups in society. In modern terms, the exercise of unilateral power is seen in more bureaucratic, rational and impersonal allocation of resources. In societal terms, it emphasises the physical, monarchial, executive function of state.

Torbert also comments that this form of power gives rise to asymmetrical relationships in which the power may be exercised through mechanisms other than physical force, for example social attraction and cognitive structures such as an organisational chart.

My own sense of the usefulness of this construction of power was that it allowed me to see how it operates currently within health services. Many individuals (as patients and as health professionals) have surrendered sovereignty to doctors over their own knowledge and power in relation to health and illness and its treatment and remediation. In turn, I saw doctors frequently appeal to this type of power in presuming there is a right way of doing things according to rational calculations and knowledge to which they alone have access. This is not the only power relationship at play, but I have observed this in operation when there is a conflict of interests between professionals.

I could also see that there may well be instances whereby use of unilateral power is required temporarily to initiate changes toward more partnership types of relationship. The challenge would be finding ways of moving on from this initial position to a more collaborative one. A possible counter to this form of power, within Torbert's analysis, is to provide alternative

cognitive structures or frames which provide a different appreciation of events under consideration.

• *Diplomatic Power.*

This comes from Rousseau's conceptualisation of power - that which is yielded by consent (as opposed to wielded by might). A leader is successful when discerning accurately what the governed actually want and presenting proposals that gain their consent. Rousseau conceptualised that an individual is free only when obeying his or her rational will, and that because rational will is internally consistent and generalisable, everyone's rational will will be the same. Hence a state governed by rational will is a state in which individuals are simultaneously united with all and free to do as they wish.

Although Rousseau draws a conceptual distinction between the general will and the private will, it is not clear how this distinction can be drawn in practical and political terms. The diplomatic type of power relates to justice as being legitimate, as being according to the peoples' will. It emphasises the democratic legislative function of state.

• *Rational, logistical power.*

This conceptualisation of power was developed by Kant who extended the rational aspect of Rousseau's diplomatic power. Kant transformed the idea of freedom as obedience to a rational will into an ethical injunction for individuals to exercise their own rational will. Only when individuals exercise reason and rational will are they free. Kant envisions a society in which, through exercise of a reason which is universalisable, individuals are highly independent and free, never coerced, persuaded only by rational argument , and afford rights to others which they would claim for themselves. Power is the ability to do something rational rather than being caused to do something by internal desire or external pressure.

In this conceptualisation of power, Torbert argues that Kant relates power, authority (legitimacy) and justice as being mutually coterminus. It emphasises the rational judiciary function of state.

These three types of power were immediately recognisable to me within my own experience. The fourth was intellectually recognisable but the practice of it seemed a complex and lifelong journey and seemed unavailable to me at the outset of the research. I will include it here as analytically linked to the other dimensions of power, but will refer back to it in later chapters.

• *Integrating Unilateral, Diplomatic, and Logistical power to create a Transforming Power.*

Torbert draws upon Rawl's (1972) theory of justice as offering a fourth type of power, one in which the above three categories of power are integrated into a vision of a just and humane society. This vision is based on considerations from developmental theory and levels of moral development as the individual moves through the life cycle. There are two principles of justice at the heart of this vision:

- Firstly, each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all.
- Secondly, social and economic inequalities are to be rearranged so that they are both to the greatest benefit to the least advantaged, and attached to offices and positions open to all under conditions of fair equality of opportunity.

The first enunciates a system of liberties to which all are entitled. The second generates additional considerations that will attract the consent and approbation of all citizens and lead to utilitarian results. Torbert sees Rawls' theory as integrating rationality, rights, consent and utility.

Rawls uses an educational paradigm in which parents formulate rules comprehensible to their children, enact a consistent morality themselves and gradually make underlying principles explicit. He sees that it takes more than reason alone for people to both apprehend principles of justice and to practice them. In a just society parents help their children develop through a process of applying unilateral and diplomatic power, love, and an awareness of incongruities between one's own reasons and actions. Torbert sees within this paradigm the requirements for the same kind of awareness he expounds in his model of Collaborative Inquiry - namely one which embraces the realms of intuitive principles, rational rules, actions and effects. Rawls repeats this again in his requirements for just action at a political and legal level, where an awareness is developed within the different realms of experience and incongruities among them are observed and corrected (I am not clear from my reading of Torbert to what extent Rawls theory of justice also informed his early work in developing collaborative inquiry).

Torbert identifies a gap between theory and practice in this conceptualisations of power and justice. There is no explicit guidance on how relatively unjust settings can be transformed into relatively just settings. He poses the question 'what type of power increases integrity, awareness, and justice, and how does a state, organisation or individual cultivate such power?' His answer to this is the concept of *power of balance.* He takes the four conceptions of power and links them with a proposition from Plato - the belief that individuals can repeatedly reconstruct the world in the face of crises or dilemmas in which current assumptions and logic do not equip them to resolve. Resolution is achieved through a revising or reconstruction of beliefs and assumptions about the world.

This is at the heart of the developmental model he formulates about managerial leadership. As individuals or acting systems move along developmental stages they increasingly exercise a dynamic blend of the four different types of power to achieve a 'Power of Balance'. I will summarise this model of leadership next, then follow with some commentary on it.

A developmental model of leadership.

Torbert proposes a developmental model of leadership in order to address the question of 'how can persons develop the capabilities required to exercise transforming power?' I include

a brief description of the model here because it is an integral part of the concept of power of balance. The different stages are presented here in order of increasing level of development. As a series , the stages represent a sequence of transformations through which an individual can progress towards an increasingly complex and holistic mode of being and acting in the world. It is only after the first four stages that Torbert considers an individual to be acting in a transformative manner. The first four represent world views associated with the four different approaches to power and justice outlined in his analysis of power. The later stages involve multiple and interacting use of the different types of power in transformative ways. The characteristics are summarised in the table below.

A DEVELOPMENTAL MODEL OF LEADERSHIP

STAGE	GOVERNING FRAME	LEVEL OF AWARENESS
Impulsive	Impulses rule reflexes.	
Opportunist	Needs, interests rule impulses.	Outside world, effects.
Diplomat	Expectations rule interests.	Socially expected behaviour, practice.
Technician	Internal craft logic rules expectations.	Internal logic, thought.
Achiever	System success in environment rules craft logics.	System success in environment, interplay of plan, practice, effect.
Strategist	Principle rules system.	Theory of historical development of system - environment.
Magician	Process awareness (interplay of principle/action) rules principle.	Interplay of consciousness, thought, action and environment in Eternal Now.
Ironist	Intersystemic development awareness rules processes	Interplay of self and other systems in Kairatic History.

From Torbert (1991)

A sample of the managerial styles associated with the different stages are as follows.

- *Opportunist:* Occupy a utilitarian ethical position. Have short time horizons; focus on the concrete, are manipulative and deceptive, reject feedback, externalise blame, are mistrustful, have fragile self-control, use hostile humour, flaunt power and sexuality, view rules as loss of freedom, punishes according to 'an eye for an eye', treats what one can get away with as legal, and has a positive ethic of "even trade".
- *Diplomat:* Occupy the ethical position of Rousseau and power through consent. They observe protocols; avoid inner and outer conflict, work to group standards, speak in clichés and platitudes, conform, feel shame if they violate norms, seek membership of immediate group; positive ethic of being 'nice' and cooperative.

- *Technician*: Interested in problem solving; seeks causes; critical of self and others based on craft logic; values efficiency over effectiveness; accepts feedback only from 'objective' craft masters; sees contingencies and exceptions; wants to stand out; positive ethic of sense of obligation to wider moral order.

- *Achiever*: Long term goals; future is inspiring; welcomes behavioural feedback; effectiveness and results oriented; initiator; appreciates complexity; seeks generalisable reasons for action; seeks mutuality over hierarchy in relationships; feels guilt if does not meet own standards; blind to subjectivity behind objectivity; positive ethic is practice of self improvement based on self chosen ethical system.

- *Strategist*: Delights in paradoxes, anomalies and unique events; respond to historical process as it generates events, not just goal related outcomes; commitment to theory which helps interpret events creatively and generate new order and organisation; all frames, including own, are relative.

- *Magician*: Continually re-invents own frames and is re-framing; tunes self to frames held by other actors, and to underlying historical and organisational rhythms; seeks the motivational challenge of each situation in its uniqueness; appreciates polarities and acknowledges the ongoing relation between them (dark and light); open to the opportunities for transformation in seeming disintegration; engages in action inquiry as social ju-jitsu.

- *Ironist*: Masks own reframing powers; more indirect, lower profile and impersonal; focuses on how the developmental process can be socially institutionalised; resulting liberating structures would make sense to organisational members at various stages of development and invite transformation; distances and tensions between actual and ideal accepted as part of essential condition of life, to be transformed when possible but never obliterated; cultivates high quality awareness across whole enterprise; allows an ironic interplay between outer 'mask' and authenticity.

I will conclude this chapter with a brief commentary on what I saw as the difficulties Torbert's power of balance posed for me at this stage of the research.

Commentary on Power of Balance.

The difficulties I had related to the developmental model of leadership, and to the concept of a transforming power.

Firstly, with regard to the leadership model, the concept of a developmental scale with an associated questionnaire which can be used by a researcher to rate others along a continuum of development raised questions for me as a psychologist with an original training in psychometric testing. I found myself asking questions such as 'how was the scale developed and on what population with what characteristics, what is the theoretical model of development from which the concepts are drawn, what are its psychometric properties (such as reliability and

construct validity)?', and so on. This located me back in the territory of a traditional model of science, concerned with objectivity, with generalising across time and settings, and with prediction and control. I found it hard to reconcile this with the spirit of the emerging paradigm concerned with local knowledge and an intersubjectivist epistemology. I found it unbalancing in a way which seemed to tilt me away rather than towards collaborative inquiry as I saw it.

Secondly, and closely following this, I found the idea of locating other peoples' abilities within this model had the effect of positioning me as making uncomfortable judgements about them independent of the differing contexts which give rise to the meaning of any behaviour or relationship (including my own). For me the language used to describe the characteristics of the leadership styles implicitly devalues the first four stages in relation to the last three. In thinking about using these as a framework through which to view myself and colleagues I found myself in a 'me-and-them' distancing mode which ran counter to the frames I had at the time. I held 'joining-with' and 'valuing-everybody's-potential-to-contribute' as dominant frames. While I do not wish to present myself as someone who does not make judgements which are at times critical and evaluative, I did not feel comfortable with adopting a model which seemed to hold me in this frame. It was certainly possible to see myself and colleagues behaving in ways which fitted the descriptions (both the positive and the negative). But in so doing I found it difficult to then either re-label behaviour or re-frame situations in a way which allowed for more flexible alternatives and possibilities. While there is merit in 'calling a spade a spade' sometimes, I could find little use for this as a beginning researcher. I also felt dwarfed by it.

These objections seem at odds with my use of the concept of life-span development in clinical practice. The latter is trans-theoretical heuristic which attempts to understand the notion of development as continual flux and discontinuous change, made sense of by individuals according to the social and cultural contexts in which their lives are embedded. It is also bounded by markers such as birth and death.

Thirdly, Torbert's 'transformative' power and his overall concept of the power of balance seemed unavailable to me in the early stages of my research. I saw it as requiring access to unilateral power to initiate changes and that this would need to come through formal authority or position which I did not see myself as having. I saw my own power base as coming from experience and tangible expertise which I could offer, and which others might or might not see as relevant. As such, diplomatic and rational power were the only forms I saw as being available to me.

Although Torbert sketches out his own notions of the organisational context within which his concept of leadership development takes place, I did not see this as an available context for taking meaning for myself at that stage.

It is not doing full justice to Torbert's model of a Power of Balance without also elaborating on his notion of a Community of Inquiry and the qualities of liberating structures which an organisation needs to cultivate in order to support transforming change. However, at that

stage I was only beginning to apprehend the relevance of action inquiry at the more interpersonal level around my own case work, linked to the notion of 'experiments in practice'. I was still seeking a way of achieving authenticity before I could call what I was doing 'research' and not 'merely practice'. I will draw more upon Community of Inquiry and the implications for interpersonal strategies for inquiry as they become more germane for me later in the research journey.

Meanwhile, I wondered if the explicit use of the interpenetrating attention span, operationalised as framing, advocating, illustrating and inquiring, would help me inquire more rigorously into my practice. In the next chapter I present two stories about practice and reflect on them in relation to the research frameworks I had developed so far.

8. SEEKING AUTHENTICITY AS A RESEARCHER.

Introduction

This chapter is about a more conscious effort to explore how my practice and the research methodologies and ideas presented so far could become more intertwined. Whilst the constructivist ideas from Lincoln and Guba's Naturalistic Inquiry had spoken to my practice (and my thinking about practice), and had helped elaborate my appreciation of epistemological considerations, I felt that the action research methodologies were still 'waiting in the wings'. My central concern was about gaining explicit collaboration from others to join me in inquiring into the issues involved in working with 'complex cases'. Both Cooperative Inquiry and Collaborative Inquiry as I saw them required this as a first step. I could not become an 'authentic' researcher until I had gained this.

I present two stories here to illustrate my dilemmas in achieving authenticity and collaboration. The first is about my attempt to put into practice an element of Torbert's 'experiments in practice', through use of his Framing/Advocating/Illustrating/Inquiring interpersonal strategy. I did this in the context of an episode of practice in which I departed from my usual role of coordinating care and came away feeling that I had been inauthentic as a practitioner, and clumsy in my use of Torbert's inquiring interpersonal strategy which I felt had hindered rather than helped. I felt doubly inauthentic, as both a practitioner and as a researcher.

The second story is one in contrast to the first. I did not engage in conscious use of Action Inquiry strategies, but rather I paid more attention to the constructions held by the different 'actors in the drama'. I found the results to be much more satisfying to me as a practitioner and I saw the process and the outcome as being informed by the increasingly detailed 'map' I had constructed of how the department functioned, as described in the previous chapter. I felt this 'map' allowed me to gain the necessary degree of collaboration to effectively resolve a 'painful' situation. However, this story troubled me as a researcher because in it I felt increasingly removed from the possibility of gaining the explicit collaboration I was seeking as a criterion for beginning the 'research proper'.

The outcome of both stories for me as a researcher was a heightened sense of dissonance between practice and research, and this tilted me towards a crisis.

Both these stories were written around the time of the occurrence of the events reported in them. Apart from some polishing in response to successive readings, and in response to feedback from supervisors, fellow research students at Bath, and family, they are presented here as initially written. My story-telling style this time is a more narrative one without dialogue, and I claim the warrants I laid out earlier for these two stories. This is my representation of the 'truths' as I saw them, taking into account my own framings purposes and values, and presenting others' views as authentically as I can within my understandings of them for the purpose of this research. There are other 'slants' on the episodes which could be told, or other

stories within this which could be elaborated. The ones I present here are written as the ones which I experienced. I make commentaries on the meaning I take from these stories, both in action and at the time of original writing, and now at the time of creating the final research narrative.

Eddie's story - seeking authenticity as a researcher.

Because this case linked so many issues together for me I found it difficult to write about at the time. As I read it now I see it so much more richly, through the lenses which I subsequently developed. However, I wish to honour how I made sense of it at the time so that I keep to my purpose of telling the story of my development as a researcher as an unfolding journey of discovery. It will be difficult to authentically relate the frustration and the sense of self doubt this episode created in me, so I am noting this now. To aid this I will develop the story in terms of the action around the case, my reading of the issues, and my attempts at being explicit in creating an 'inquiry niche'. This latter term refers to my conceptualisation at the time of how I might proceed with research - exploring possibilities within relationships or around episodes for further explicit collaboration and participation in such a way that it constituted 'research' and not 'merely practice'.

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Eddie.

Eddie was a young powerfully built man of mixed Afro-Caribbean and European origins who lived in another district some distance away. He was an injecting drug user who had been referred by a General Practitioner who supported the local drugs services. The GP had been prescribing the injectable opiates but had unilaterally withdrawn this because of Eddie's inability to "keep to the rules" as he saw it. The only option he had offered was a detoxification followed by admission to a long term rehabilitation centre. We were asked to provide the detoxification as the rehabilitation centre was located nearby. This was not Eddie's preferred course of action at the time but he felt the only other option open to him was to revert to street drugs and the criminal lifestyle needed to obtain and pay for them. He had also been made homeless and so felt that street drug option held too many risks for him. However, he saw himself as still being heavily dependent on drugs and very ambivalent about becoming drug free.

Eddie presented himself to me as someone who was both 'street wise' and at the same time familiar with institutions. From the outset he quickly told me about his history of being in care as a child, followed by periods in psychiatric hospitals in adolescence and early adult life. He used 'therapy' language with an easy familiarity which suggested a certain sophistication while at the same time impressing as being boyish and vulnerable. He told me how he tended to leave hospitals after conflict with staff where there was threatened or actual violence on his part and asked that whatever the outcome of his admission here that he be "able to leave with dignity". Despite his apparent frankness and ease with which he had related this to me, I was

left feeling as though I still knew very little about him as a person. Already around the ward he had been noted to be emotionally labile with a low tolerance to frustration and given to storming off if his needs were not immediately met, then coming back contrite some time later.

Because we had a rehabilitation centre on our 'back doorstep' we were often asked to provide detoxification prior to entry on behalf of services throughout the country. This meant that we regularly admitted people to find that there was much relevant information which had not been given to us earlier on and that this could change the goals. It could lead to admissions which were inappropriate and costly, both to the person and to the services involved and at this stage we had not developed procedures to improve this.

The Senior Registrar had completed the initial assessment of Eddie and had arranged the admission before referring him to me for psychological treatment of a particular problem. Eddie used opiates by injection only and did so in a compulsive manner which he felt was beyond his personal control and hence unable to stop. The significance of this for the admission was that he was unable to transfer easily to an oral form of opiate necessary for a medically safe detoxification. My task was to provide psychological treatment for his compulsive behaviour so that he could then proceed with his detox.

I decided I would limit myself to this specific role and leave the wider responsibility for the case with the Senior Registrar who was his 'Key Worker (a role we had by then begun developing, one which involved overall responsibility for monitoring the 'Patient Journey' through the service). I had not been part of the original assessment, goal setting or contracting about the nature of help to be given. Neither had I been in contact with the referring agency or met with the client prior to the admission to take part in any negotiations about what would be the most appropriate form of help at this stage.

Because I had no direct control over scripting with drug dependent clients I decided I would not get involved in that aspect of his care. I had found that role too frustrating in previous cases. The role I had been asked to take felt like a more traditional psychologist's role - take on only those aspects of the problem over which you have control of the expertise and the resources. Despite seeing many pitfalls, I decided I was going to keep to it in this instance.

In referring to the 'traditional psychologists' role, I do not wish to demean what many psychologists who work within multidisciplinary teams are trying to achieve, it is more a limitation of the prevailing model within clinical psychology with its treatment methods strongly rooted in the traditional science paradigm. However, many psychologists work outside multi disciplinary teams in isolation, taking on only those problems which fit their chosen model/s.

As I began to work with Eddie and find out more about the circumstances around his admission, the more I began to wonder at how I was going to succeed in keeping to the narrow role I had elected to follow. I did not feel his host agency had demonstrated good practice by providing realistic choices and continuity of care and where all those involved,

including the client, participated in a collaborative fashion in the decision making. There was a background then of a complex mix of purposes and agendas, with an element of coercion. I had learned that to minimise the impact of this pattern one needed to be involved at the point of referral to try and redress these imbalances. I began to feel cross that such a situation had built up in this case (losing my usual framing of such situations as 'services under-resourced and over-stretched and in times of crisis selecting solutions such as these to minimise the stress'). I was feeling protective about the client as well.

At this point I speculated about the issues I faced. Clients like Eddie tended to be seen as 'difficult to handle' and staff easily retreat into seeing the problems as lying within the client rather than as an outcome of the quality of the interaction between client and staff. This leads easily to a labelling process, the client being seen as denying, rationalising, angry/violent, manipulative, 'splitting' the staff against each other and so on. Such labelling leads to staff taking on positions of confrontation or avoidance which then tend to make matters worse and create self-fulfilling prophecies. There were indications that this process had begun well before his arrival here.

I wondered how much the current nursing team would be able to cope with him in more collaborative ways. Things had moved on since the incident on the roof in earlier days and we were all more easily able to "go with the flow", a term sometimes used around the department. Nonetheless the personnel in the nursing team changed regularly and it was not easy to predict what the culture was within that group. In addition, the nursing team had identified that when there were more than four drug users at any one time as inpatients (out of a total of eleven beds) then there was an identifiable culture change within the ward, as if the street drug culture was imported in. This was recognisable in a high level of complaints, reduced cooperation, increase in incidents of illicit drugs brought on to the ward, stealing of patients property, conflict over medication levels, and threatened and actual violence.

When this occurred, the nurses came under increased stress and tended to retreat into more defensive ways of working. They did not always feel listened to by Stewart who would complain from time to time about the difficulties he had in getting the nurses to accept enough drug admissions. Under stress he would retreat to a position, as I saw it, of 'why can't the nurses keep these patients occupied and mop up the problems - as a doctor I should not have to be bothered by demanding patients'. William on the other hand had developed a more sophisticated analysis of what nursing was about. He had come to understand that the provision of a care environment was primarily a nursing responsibility and that he needed to negotiate admissions with them, accepting the nurses' judgements about their ability to care for any particular patient, taking into account the patient's needs and the environment on the ward at that particular time. If there were problems he would become involved in finding solutions as he knew the operation of the ward would be jeopardised if crises were allowed to escalate beyond a certain level without intervention. He recognised that there were times

when use of his formal authority was necessary in order to support the nurses in maintaining a safe environment. However, to my knowledge he never openly challenged Stewart about his approach.

A further issue facing me was the difficulty having someone injecting drugs on a ward where other drug users were attempting detox. We had been able to achieve the shift away from 'abstinence as the only goal' to create an environment where some clients could be admitted for assessment while still using, but there were occasions when this kind of arrangement created a good deal of tension with other patients. Given the process by which Eddie had been referred, and given his ambivalence about making change, it was highly likely that there would be conflict over his script as change became imminent. It was also likely that he would not be able to proceed through to the point of completely detoxifying from drugs and that he would want to leave with a continuation of his injectable script. This would be another point of conflict as our doctors were very reluctant to provide these, except under certain conditions, because of inherent health risks and difficulty monitoring them. However, the decision to proceed had already been made and it would have to be followed to some conclusion. This was another factor beyond my control and further evidence to me that I should limit my role.

Then there was the issue of how to work with someone like Eddie. He presented himself simultaneously as a streetwise drug user, as an 'experienced psychiatric patient', as potentially violent, and as vulnerable and powerless with few options for change at this point in his life. I had been able to learn little about his history of relationships but presumed that he had little experience of trust and collaboration.

My usual approach in these situations, where the person is acting in such a way as to minimise their credibility and is likely to be negatively labelled, is to first accept the different 'truths' presented by the person. The challenge is then to find some way of interacting so that the person can experience themself as having choices and as taking some level of responsibility for exercising these choices. Then next to negotiate how I and the service could support or resource these choices, stating clearly any limitations. On occasions such as this, where there seems few openings to begin developing this relationship, the problem the person presents can be the vehicle needed. It then becomes a case of taking this at face value and proceeding with negotiating around the problem in such a way as to develop the possibilities for partnership in expanding choices and achieving change, no matter how small to start with. Once small changes are identified, then these can be 'cheered on'.

This approach does not mean that offensive or oppressive behaviour be ignored. It means finding the level at which the person can accept some responsibility for it then both challenging and supporting them in taking it. The wider challenge is to create a care environment in which this can occur and be noticed and affirmed. In this way I believe people can be moved out of 'patienthood' into 'personhood'.

An accompanying belief is that we all learn and develop our sense of self esteem and self agency through making successful transitions, large or small. Most mental health problems occur around times where transition is required but is not successfully negotiated, for whatever reason. Therefore beginnings and endings are important. If I can work with clients in negotiating successful beginnings and endings in their contacts with services, then this will set the scene more productively for any further contacts in the future. Eddie's plea to be helped leave with dignity struck me as particularly poignant. I felt myself wanting to advocate that strongly on his behalf. If we could help him achieve this then he would be more likely to feel he could return at some later stage when the conditions were more favourable. Furthermore other people would be less at risk from the violence which Eddie had hinted had occurred during previous admissions.

These latter considerations lay in contrast to my decision to limit my role and so set up conflicting purposes, because it would be unlikely that I could achieve these objectives within a limited treatment role. I warned the senior registrar of the different outcomes I could foresee happening and we agreed on the need to monitor developments.

So I began work with Eddie with multiple and seemingly incongruent purposes. I had to manage the tensions of working between these two opposite poles. I started off accepting his definition of the problem as being his inability to resist his bizarre injecting rituals which were highly risky and very self damaging. These rituals lasted for up to an hour and afforded subjective relief from distressing thoughts. I set up the conditions in which he could achieve this, involving the nursing team, Eddie and the senior registrar.

Over the period of several days Eddie's goals changed successively, from wanting to detox, to then moving off injectable drugs, to then being able to continue injecting but in a safer manner. With each change of goal, the nursing team and I negotiated how we could help with this and we alerted the senior registrar.

After several days the senior registrar asked me to accompany him to one of Stewart's outpatient clinics to review Eddie's care. He had apparently been "splitting" the staff and the senior registrar needed to review how to handle the situation with Stewart.

By way of comment at this point, I had recently discussed with two men on the nursing team what constituted a 'difficult case' for them. They both thought the primary indicator was when the staff were "split" over them. This was a jargon word within mental health circles, originally from Object Relations psycho-analytic theory, indicating that the patient constructed different staff into either 'good' or 'bad', with the consequence that each group took either a positive or negative view respectively of the patient, and thus came into conflict with each other. It contains a partial recognition of the interactional nature of reality, but tends to be used in a more pejorative sense in which the outcomes are seen as due mainly to the patients manipulations.

I was rather surprised at the "splitting" comment because I thought we had handled that by keeping abreast of Eddie's ambivalence and changing goals and had kept each other informed about what was happening. On the other hand I was pleased the senior registrar had suggested a wider meeting than he and Stewart alone and outside the usual routine meetings which did not always have the relevant people present. It was usually a role I played to collect together all those involved (even though this meeting was not to include a nurse) and I was pleased that someone else was picking this up.

I decided to keep to my limited role and accept his invitation as it stood. After all the decisions would be about drugs and that was their realm of authority and responsibility. In addition, Stewart's outpatient clinics were not a setting for collaborative and authentic inquiry, where people could acknowledge uncertainty or 'not knowing' very easily without making themselves very vulnerable. Stewart ran his outpatient clinics in a very leader-centred way with little dialogue occurring between team members. He often had medical students sitting in and would without warning throw a question to one of them and then engage in a socratic dialogue for several minutes while the rest of the team had to sit and watch. This went unquestioned, this was how medical students were taught. Nobody challenged because they did not wish to be part of the process.

Despite all the reasons I could see for keeping to my limited role, I had mixed feelings about the process. On the one hand I felt I wanted to take a back seat in the decision-making for all the above reasons. But I was also feeling a little 'bloody minded', thinking to myself: "I am tired of mopping up the mess around doctor's failure to keep full responsibility for the consequences of their decisions about drug prescribing. Let them deal with the consequences this time."

Then there was another voice which was saying: "But Eddie is very preoccupied with his script, you can see trouble brewing over this, you are concerned that he does not paint himself into a corner and that we find a way of working with him which gives him meaningful choices and allows him to participate in as collaborative a way as possible. How are you going to achieve this if you take a back seat in the drug discussions?"

Another voice was saying: "Maybe you are a bit perfectionistic, can't allow others to make mistakes. You have had that feedback before. Maybe you should stand back and let them have a go."

After hearing from the senior registrar and myself (keeping to my limited role, describing the outcome of my treatment interventions), Stewart made his views clear. "If he's serious about detox then we can't wait longer than a further week for him to deal with his compulsive injecting problem and get onto oral drugs. If he does not want to detox but merely deal with his injecting, then OK we can give him a bit longer providing his referring district are willing to pay for this. On no account am I willing to discharge him on injectable drugs. His injecting is too risky and I do not want to be responsible for it continuing."

I was caught in a further bind. "I can understand Stewart's reasoning and it is straightforward. However, Eddie does not feel as though his injecting is under his personal control and he came here in the context of his drug service unilaterally withdrawing his script. If he does not feel he can proceed with a detox and if in the short time available cannot deal sufficiently with his compulsive behaviour to switch to oral drugs, then it seems unfair to discharge him without an injectable script. But on the other hand, its not my job to make decisions about prescriptions, I have given my point of view and the doctors must cope with the consequences of this decision."

This internal dialogue left me feeling anxious, but I was in a bind. If I advocated a different approach based on my private understanding of the case this would not feel timely. Things had gone too far and I had no power to effect the outcomes I would like. But I did not like myself for not giving voice to how I saw things.

With these conflicting internal agendas, or voices, I offered to be present with the senior registrar and the key nurse in discussing the different options with Eddie. This seemed appropriate to my limited role in that I was not up to date with his current thoughts on what he wanted to do and so thought that it was important that all three of us meet with him to minimise any further confusion. But I also harboured hopes I could keep open the possibility of as full and open a collaboration as possible in the circumstances.

Eddie elected to meet us in his room and he made it clear he understood the options he was being offered and clearly voiced the dilemmas he was in. Consequently he had decided to leave. He then asked for an injectable script, hinting that it would need to be larger than the one he had been receiving during his admission otherwise he would probably need to obtain additional 'street' drugs. This was a familiar 'opening gambit' which I had observed frequently when dependent drug users were requesting a script from a doctor. I anticipated that we were in for conflict.

At this point I suggested we take a break from the meeting so that as a staff group we could consider his request. I needed to hear how the other two were making sense of this and what they wished to do so that I could decide what role I should play.

This situation had all the hallmarks of being a repeat of how Eddie had left previous treatment/care situations and had the potential for unnecessary conflict and possible violence which I was keen to avoid for everyones' sake. In our break I voiced the view that while it was clearly the doctor's prerogative to decide, I felt that there was grounds to give Eddie an injectable script for up to two weeks to enable him to find accommodation somewhere and register with a drugs service if he so chose. I ran over again the circumstances under which he came here, that he was already on an injectable script anyway, my belief that he would not accept an oral script without escalating the situation, my belief that if he left in anger it would make it extremely hard for him to come back in the future, and that he was clearly not able to give up injecting as it had a strong compulsive element which meant it would not be under his

personal control without some intensive psychological treatment. I also pointed out that Eddie had repeatedly asked for us to work with him to avoid such a situation.

The senior registrar's position was that he had been willing to prescribe injectables until he had heard Eddie say he would probably use street drugs as well, in which case the whole point of prescribing was lost. The nurse took the position that Eddie was clearly being manipulative and to go along with his request was to give in to his manipulation. Both these positions had a strong 'truth' to them and I began to doubt whether I was giving Eddie too much 'benefit of the doubt'. Was I being "pathologically benevolent and positive" as my colleagues sometimes teased me. The senior registrar and the nurse reiterated their agreement with each other.

At this point I realised I had decided to depart from my limited role. I felt I had to see this through rather than opt out at this stage. Perhaps there would be something I could do yet to achieve the most 'dignified' departure possible in the circumstances. So, I registered my discomfort at the decision but said I would go along with it because it was the senior registrar's prerogative.

As an aside, I recall that in my reflective diary at the time I also noted that I had felt an obligation to share 'the dirty work'. This was an old agenda which arose at times when I was feeling uncertain or ambivalent about what role to take in relation to nurses and doctors in inpatient settings. I related it to my early experiences in acute psychiatric ward of feeling left out of the action and feeling it was perhaps because I had not 'worked hard enough'. This latter was a familiar script arising under stress. It was also grounded in the current context. The nursing staff had been making comments recently about the "upstairs/downstairs" divide. My reading of this was that the comment tended to be made when they perceived themselves as working in isolation and not feeling supported by the consultants, arising usually when there was a particularly demanding group of drug users on the ward. But it was also generalised to most senior staff whose offices were upstairs from the ward.

Eddie became predictably angry on hearing of the decision and argued his case more strongly. The senior registrar alternately stuck to his guns or sat listening to him and tried to placate him by empathising with his anger. The nurse similarly tried to placate him. I said nothing initially. But the situation began escalating as Eddie became increasingly angry in response to my two colleagues responses. He became increasingly challenging of their decision and at times put what I thought to be a powerful argument in his favour and I found myself agreeing with some things he was saying. Yet at the same time I did not want to undermine the senior registrar and did not want to intervene in a way that got me involved in assuming responsibility for drug decisions.

However I was feeling increasingly uncomfortable about the conflict as I could not see how it would end with mutual agreement and the other possibility was that Eddie would become physically violent as he was pacing around the room, picking up his belongings and vehemently throwing them into his bag. I could not read clearly what he might do. I was

becoming impatient with both the senior registrar and Eddie. I was dismayed that Eddie seemed to be digging himself into a hole and was not able to hear whenever I attempted to say something to him. I could not work out what the senior registrar was thinking, his statements said "no to injectables" but his behaviour suggested he might be swayed. What did his silences mean? His continuing the conversation and his reasoning with Eddie seemed to have the interactional effect of increasing Eddie's anger and his statements about being "patronised". While this went on, with Eddie pacing the room, the other two sitting on his bed, I kept watching Eddie's body language closely. As I was squatting against a wall in the absence of another chair I made sure that I always kept the space between Eddie and the door clear so that at no time would he feel trapped in the room. I also avoided being directly in front of him and would move to his side but within his line of vision so that I kept a 'joining' position in relation to him rather than a confrontational position. I would also be in a position to restrain should the need arise.

It was clear Eddie was not going to accept the senior registrar's decision reasonably so it did seem patronising to me to try to prolong the discussion and convince him of the rightness of it. If he meant "no" he should say "no" and end the conversation there and then and avoid further escalation. Being tactful and assertive about a decision affords the other person the dignity of knowing where they stand and assumes they will be able to make choices in the light of that.

Eddie was not indicating that he heard what anyone was saying to him by now, particularly me, and was becoming increasingly contemptuous and blaming and was beginning to misrepresent things said in earlier conversations during his stay in his favour. I was feeling I could not continue sitting on the sidelines and watch this, no matter whether or not the senior registrar experienced loss of face by my intervening. If this was a tried and true method Eddie had evolved over many years of obtaining drugs then it did not strike me as very adaptive and not one I wanted to participate in.

I said: "I think we should stop at this point, we are going around in circles". Then to the senior registrar: "Have you heard Eddie say anything new which changes your mind?" He affirmed that he had and then offered a compromise to Eddie which was accepted in a derisory manner after some further attempts at increasing the dose.

The meeting was ended by the senior registrar saying the 'door was open' if Eddie changed his mind and wished to return. Eddie rejected this out of hand, still angry. Then there followed a moment of humour as Eddie's demeanour lightened and he asked if he could stay one more night as a friend coming to collect him may not be able to come in time. We agreed and all laughed and relaxed. There was a shaking of hands and I could not resist joking to Eddie that he should think about taking up Law. I wondered now whether this had been an elaborate charade and that my concerns had been misplaced - that Eddie was well practised in this

routine and that the senior registrar might also have been authentically trying to find a way through for himself.

However, I was left feeling that this could have been managed better, that it had been an unnecessarily prolonged and uncomfortable session and that I may have played a role in that by my silence and by my mixed purposes. It was also possible that I might have undermined the senior registrar in some way and been a party to him doing something against his better judgement. Usually I would have made sense of this over time, through conversations afterwards at opportune moments, through noticing responses to my engagements with the people concerned as our work progressed, through explicitly linking elements of this case to other similar cases as they arose and seemed to bear contrasts and comparisons. I would hold this frame for some time in my noticing.

However, it occurred to me in my new researcher role, that perhaps this is an occasion where I should be explicit about my inquiring. And perhaps this is a time to explore the usefulness of Framing/Advocating/Illustrating/Inquiring.

I asked the senior registrar and nurse to meet with me afterward and debrief. They agreed but looked puzzled. I framed my request as needing to resolve a dilemma I had felt between taking the client's position on the one hand and acknowledging the doctor's right to make his own decisions about scripting on the other hand - that I had been feeling caught between the two and was wondering how helpful I had been. I advocated that if we shared our perspectives there may be something to be learned from how we deal collectively with such situations in the future. They listened politely but seemed bemused as to why I was wanting to talk about this.

I illustrated by describing my observations and feelings during the encounter. I then inquired of the senior registrar how he had made sense of what had occurred. He explained that he had felt quite comfortable with Eddie's anger and that his silence had been "To give Eddie time to vent his anger and give him a sense that I could contain it, then wait until he cooled down before patiently re-stating my case".

I then inquired of the nurse. She stated that the most important outcome had been to avoid the client 'splitting' the staff and was therefore happy to support the senior registrar's decision in the meeting. She was not bothered by people's anger or that they might leave the ward without conflict being resolved. She did acknowledge that she had felt anxious on one occasion when Eddie had blocked the doorway for awhile. She also felt that my intervention to suggest a break and to question the senior registrar in front of Eddie had given him the message that I would support his 'splitting'.

The senior registrar ventured that perhaps I had been uncomfortable because I was less use to dealing with confrontations and anger because as a Psychologist I was able to take negotiating positions with people and did not have to confront unpleasant behaviour.

These were offered in the spirit of 'helping me in my dilemma' but they were also a challenge to many things I believed in and a challenge to the expertise I saw myself as having. I felt slightly demeaned by their responses. I considered how to respond and realised that these two in their roles were quite used to this type of encounter and did not see it as a particular problem. I did not want to seem defensive but I also wanted them to know who I was and considered that they may be making sense of this situation based on little knowledge about me and how I thought about things. Perhaps it would help if I talked a little about my approach.

I acknowledged that what they had said could be partly true in this setting but that I had worked in other settings with dangerous behaviour. I went on to describe my values and beliefs which underpinned the approach I took to conflict resolution, to the type of relationship I attempted to develop with clients, to respecting the dignity of all. I reiterated my belief that this could have been a potentially violent situation and that in my view we three had inadvertently increased the chance of that by the way we had handled it. This went unchallenged.

At one point in the discussion, both suggested it might have been helpful if I had expressed my discomfort directly to Eddie. I replied that I had tried three times to address Eddie but that he had not heard me - the senior registrar as doctor and holder of the prescription pad was the only person he was interested in talking to. I talked more about how I had tried various positions in the room to interrupt the escalation and that finally the only one I thought would work was to talk directly to the senior registrar. They accepted this.

By this stage I felt that I was 'working too hard' and that I was talking past them. I started to lose confidence that this was in any way useful. I felt myself stumbling as I tried to keep in mind the Framing/Advocating/Illustrating/Inquiring framework. Their verbal and non-verbal responses said to me that I was making much ado about nothing. They were listening politely but without much interest. It was time to end this but on a positive point where we could gain some agreement about how to do it differently in the future. I asked the senior registrar how in any similar situation in the future I could intervene without compromising his position or integrity. He replied: "Say to me 'I'm feeling uncomfortable with this situation, could we have a break to talk together'. I would be happy with that."

Reflections at the time.

My reflective diary afterwards read as follows.

> "Felt stumbling, hesitant, cross at them for treating it so lightly. Irritated that they may have thought of me 'he can't hack it'. Cross at them for dangling Eddie on a string, why couldn't they have been straight with him. On the other hand am I making too much of this? Maybe they were right, he was an experienced manipulator and I got sucked in. Maybe I was backing Eddie in his fight with authority and doctors. Maybe I allowed my frustration at the power issues around prescribing get in the road. Feel cross at myself for allowing myself to get caught in it. Feel foolish that I tried to influence events from a

position of so little power. Maybe I should have stuck to my 'limited role'. Felt Torbert's stuff got in the road. What is authenticity?"

"Now, stand back a bit David. What else was going on? I felt inauthentic on two accounts. Firstly in trying to work with complexity within the confines of the limited role I had seen available to me. Secondly although I had departed from that in the spirit of trying for 'dignity' I wonder what I had achieved from my explicit inquiry niche afterwards. I felt I had been preaching at them. I had departed from my usual way of doing things. I had run the risk that they had felt preached at or implicitly criticised. I recognised the familiar 'dance' between doctors and nurses and that nurses have to put up with such situations many times over and develop ways of managing stress by keeping themselves at a psychological distance, keeping their involvement within tolerable limits. Aligning themselves with doctors makes sense if they see themselves as only having delegated and interdependent roles."

"Senior registrars have to be both practising to be a consultant but at the same time accountable to the consultant under whom they are working. The boundaries are not always clear. They are in training and they do not develop long term commitments to placements because they know they will move on. They look to nurses covertly to provide guidance and support. Each senior registrar brings their own personal process to these structural arrangements. How could I convey that in the context of this discussion. I had made myself vulnerable by talking about my beliefs and values and I did not feel met in this. How can I proceed as a researcher along these lines? Framing/Advocating/Illustrating/Inquiring did not feel helpful here, it was like paying attention to some smooth involuntary action like walking or breathing and finding that I start stumbling or catching my breath. It could not contain the complexity for me or achieve my multiple purposes, many of which are in different time frames from each other. The nature of the sequencing of the steps constructed for me a linearity which does not fit my natural way of doing things. I felt I could have achieved more useful collaboration by weaving my findings from this case into future cases, bringing in strands moment by moment as they seemed timely. That is my usual way. So how do I balance the things I value about my practice with what these research ideas seem to require of me? "

I was left feeling lonely and isolated in my views. I had discovered the limits of collaboration around an individual case. I felt as though I had tried to achieve 'too much too soon', and had expected too much of the situation in terms of trying to dialogue about the complexities of the work as I saw it. I felt as though I had alienated my two colleagues from me, and me from them.

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I will add further reflections on this case for both research and practice at the end of the chapter. The following story has a similar theme, where I intervene in such a way that I seek to maximise clients' participation in the decision-making. I see this as a more successful attempt, where, unlike my approach with Eddie, I engage with the complexity from the start. However, I was left again with a feeling of isolation.

Knitting as a metaphor for practice.

The following case is one in which the metaphor of 'Knitting' occurred to me as a description of what I did in relation to the client, myself and other members of the team. I also became aware through this case of the unique role that I perceived myself playing in the department. I was to learn about the degree of influence it afforded me and also the degree of isolation and vulnerability. This story also connects me with past experiences in New Zealand in working with individuals from different cultures, and the complexity which is created by trying to discern and work with the different world views of the key participants.

I am selecting this story to show a development in my practice, where I am not consciously putting research frameworks into the foreground. I pay more attention in action to the different constructions of the individuals involved and how these might be informing the patterns of relationship around the problem. I was not awarely attempting to use ideas from Action Inquiry - it shows rather the emerging influence of listening more for the 'stories' and trusting that the action will flow from this.

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Sushi's Story.

Sushi was a middle aged woman who was referred initially to Stewart from a neighbouring health district. She had become addicted to prescribed opiate pain relief because of a protracted and severe pain problem. She had been through exhaustive physical tests as well as several surgical procedures over a five year period to try and locate the source of the pain, with only occasional and temporary relief. Stewart had agreed to admit Sushi to withdraw her from opiates and to assess her pain problem when drug free.

Several days after her admission, Stewart asked me if I would assess her to see if I could help her with some psychological approaches to manage her pain. The medical reports he had read indicated that further physical investigation was not only unlikely to reveal anything new, it was likely to compound the problem. Particularly, any further surgical investigations would cause scar tissue and adhesions which could exacerbate any pain problem, and become sources of pain in their own right. There was a strong sense that the medical services had run out of options. Her GP had clearly reached the end of his tether and was stating that he could only go on treating her under certain conditions and was unwilling to continue providing opiate pain relief.

In addition, Sushi's husband was in serious difficulty in his professional life because it was perceived by his colleagues that his involvement with her problems was interfering with his

work. His colleagues were on the point of unilaterally excluding him from their business. Also, there was an issue concerning inappropriate prescribing of restricted drugs to Sushi within her own health service and the medical authorities investigating this had been in touch with Stewart. There was considerable anxiety surrounding Sushi and her family, and it was felt by the staff. A lot seemed to be riding on the outcome.

I was keen to respond to Stewart's request because he had been discussing with me from time to time the possibility of extending our expertise in this area. Few services worked with dual problems of drug dependence and chronic pain (which was well established in the literature as having behavioural and psychological components. I was interested to see if we could work together in a more collegiate fashion where substitute prescribing was not going to be an issue. also wanted him to know about other skills I had to offer and was interested to learn more about his, in order to see to what extent we could work together where there was more mutuality.

Before meeting Sushi I decided to gain a broader picture first by talking to the nursing staff. She was Asian, as was her husband, and the nursing staff had taken this into account in care planning with her. They had asked the kitchens to make appropriate dietary arrangements, had supported Sushi in allowing her family to supply some of her own preferred food, and had accommodated to the presence of family members to share in her care. She had a daughter who had just started her first job after completing university, and was now living away from home. Her son was studying for A levels and still living at home but due to leave for university the following year. The two children visited and stayed as often as they could, and the husband visited in the evenings. The husband was a high status professional and Sushi a worker in her local community, developing educational resources for women.

I also read her records and saw that she had been referred to the psychotherapy section of the hospital many years ago for treatment of depression. With this information I began developing some tentative hypotheses in relation to family, culture and migration issues.

My first impression in talking to the nurses was their high level of anxiety and distress. Sushi had been in constant pain and required assistance in moving about and in toileting. She spent all her time in bed even though she could find no tolerable resting position. She was in tears most of the time and expressing feelings of hopelessness and despair, often in a manner distressing to those around her. The nurses found her difficult to engage in working with them because of her high levels of distress and were only able to manage caring for basic physical needs.

Sushi was also saying she did not need to be in a mental hospital because her problems were medical. The nurses were feeling distressed at her distress and feeling helpless in relation to her continuing pain. I questioned whether they had noticed any departure from this pattern and found that she appeared to be less distressed when someone was with her, and most distressed after her family had left after visiting. However she was agreeing to pursue the

withdrawal from opiates despite the pain as she evidently felt very ashamed of her dependence.

My knowledge of pain management required that some time be initially spent with the person establishing their beliefs about causality and in developing an understanding that psychological treatment did not imply the pain was imaginary or in any way fictitious. The next step is establishing a partnership relationship in which the person is willing to take small risks in becoming more physically active and in developing more self awareness about how the pain 'works'. These steps are initially counter-intuitive to people with pain problems who believe they must rest and guard against the pain both physically and psychologically. (I had experienced a prolonged and on occasions severe pain problem myself, and so knew this with a personal confidence). This can lead to a wide range of interventions involving other therapists, such as physiotherapists, as well as family members who may have become organised around the problem in ways which inadvertently maintain it. Medication prescribed for pain relief must be managed in a particular way if the person has become dependent on it to the exclusion of other strategies.

In addition to this broad framework, I was aware from both past experience and the professional literature that different cultures not only experienced pain differently, but had different explanations and solutions. Asian health workers had written about how in western countries their people often presented a pattern of physical problems to medical services as code for psychological distress, whereas their western counterparts would more likely present problems in terms of emotional difficulties. This was explained in several contexts: the context of linguistics, with fewer words in their vocabulary to express psychological distress as we know it; the context of values; and the context of certain patterns of social and family organisation. This body of literature also highlights cultural difference in the degree to which the interests of the individual are inseparable from and subordinate to the interests of the wider family and social group. This was seen as being historically adaptive to a rural and often subsistence lifestyle in their country of origin.

Within these frameworks I tried to makes sense of the requirements of Stewart and the wider medical network, the nursing team, and Sushi and her family. In terms of my role I wanted to begin my assessment within a family and cultural context. However it would be difficult to do this within the current climate of distress. I decided some immediate action was required which was not within my brief, but which was necessary for me to succeed. My initial hunch was that Sushi needed someone to be with her constantly, that she would experience being alone in a room as a form of alienation and fragmented identity (this was a generalisation from my experiences with Pacific people who, like Asian people, saw their identity strongly embedded within the family group and who became very disturbed at being alone in hospitals). It was clear the nursing team could not manage this within existing resources, so I contacted Jan and

asked how we could achieve this. She agreed to bringing in someone from the Nurse Bank specifically for this purpose.

I then contacted the hospital physiotherapist and asked her to assess and see if she could help Sushi find more comfortable resting positions and give advice about moving her about more easily. It turned out she had worked with Sushi in a former job and was not hopeful of being able to do anything for her, but was very willing to try again. I had mixed feelings about taking these actions as it felt as if I was moving into the area of nursing care and did not wish them to feel disenfranchised. However, on the other hand they were acknowledging they were not coping and on checking I found that they were happy for me to take the lead.

My next step was to visit Stewart to explain how I was approaching this case. I needed his support because without it the nurses would feel divided if he expressed a wish to take things in a different direction. I also needed to know his views on how he wished to approach Sushi's requests for further medical intervention. I had learned that one of the junior doctors, who had recently spent some time working in the relevant medical area, believed there were some further possible explanations for her pain which had not been excluded. I wanted to make sure he knew this. And finally I needed to know how he planned to meet her requests for alternative medication for pain relief, as this would have a bearing on how alternative pain relief strategies could be introduced.

Stewart then made the decision that a further particular test was indeed warranted. We realised we would need more time and that there was some work to do contacting health services from Sushi's home health district to ensure we had all the information available, as well as gaining agreement from the purchasing authority for an extended stay. We negotiated who would take on which tasks. I had been party to some of the negotiations about service agreements with other districts and knew what needed to be done in this regard with the administration team so took on the task of arranging extended funding. I suggested that it would be appropriate for us both to meet with Sushi, for me to introduce myself and for us both to explain how we wished to work with her from here on. I thought it would be important for Stewart to outline the plan.

We did this and I was mildly surprised to feel as though I was in a ward round of a general medical ward, with the consultant doing his daily review (I had recently been in a medical ward as a patient). We did not have ward rounds in this way and I had never seen Stewart interacting with patients apart from bargaining with illicit drug users over scripting. He briefly but sympathetically asked Sushi how she was feeling, introduced me, then outlined the care plan and confidently predicted that it would be helpful to her. This seemed to me to run the risk of not meeting how Sushi saw the situation at all, but she did not signal disagreement. Indeed she agreed that she would need some psychological help. I explained that as a first step I wished to meet with her together with her family so that they could help me begin to understand what seemed to be a very complex situation. She was willing to do this.

Over the next few days I negotiated with family members about convening a meeting with them. I checked regularly with the nursing team and supported them in working with her and the physiotherapist to help her become more comfortable. She was less distressed since the advent of more continuous nursing care and was even contented to be alone from time to time. However I felt some pressure to be moving more quickly by doing some work with her myself, but decided that it would be premature without first understanding what territory I was working in.

Both the son and the daughter visited Sushi during this period and requested to see me. I met with both briefly on separate occasions and heard their very clearly stated dilemmas about their worry and concern for their mother versus their need to get on with their own lives. The son was particularly vulnerable in this way and spent a lot of time caring for his mother with the nurses, often fiercely advocating his mother's needs if she was in distress or discomfort. The daughter provided a marvellous cross-cultural bridge as she was keen for me to understand that she stood in two worlds and that I must appreciate what the issues were for them as an Asian family. She was particularly articulate about her need to get on with her own life.

The husband was working long hours to ward off pending challenges to his position from colleagues and could only come during the evening some days hence.

It was tempting to succumb to the many anxieties and begin intervening with the information I had, but I was clear that I first wanted to meet with them all as a group including the husband. I needed to gain a picture of how they were dealing with this collectively as well as individually before then finding a focus for work on which all could agree. I had to persuade Stewart to be patient as he was worried that nothing would change and we would have her "stuck here" in her continued distress. Although I had talked about my rationale for approaching thing this way, I do not think he fully understood. I had a strong hunch then that he did not know how to manage this case but could not say so overtly. However he agreed to go along with my plan.

I finally managed to convene a time when all could visit but at the last minute the daughter could not attend. I wondered if this was a metaphor for her statements to me about the need to develop a separate life, and was it a sign of confidence that she felt I had heard her?

I felt the need for a co-therapist for this meeting to provide support in observing the process and to ensure Sushi's voice as a woman would be heard in the session. As Jan and I had worked together with families from other cultures in the past I asked for her to act as an observer. I needed to have support from someone who would know what I was trying to achieve in dealing with the problems this way as it felt a lot was riding on the outcome. I had counted on the daughter to provide the cultural consultant role, but would have to do without.

I was surprised to see Sushi walking unassisted into the session, although she came with pillows to support her. By now she had completed her withdrawal from opiates. Within the family session it emerged that there had been a long standing issue about Sushi's coming to

this country for an arranged marriage and her grief at separation from her mother and family. As her children came up for separation Sushi was facing a second abandonment. She had made herself a strong role as centre of the family and mainspring for all their developments. While I joined with the men, Jan joined with Sushi. It emerged that each member of the family were facing difficult transitions in their lives. At one point Jan offered to Sushi that perhaps her role was also to carry the pain for everyone in the family. There was a long silence and tears from all as Sushi nodded.

We moved on to what they wanted to do about this. The son spoke for all the family in saying that they believed there may still be a physical cause for Sushi's pain and that they felt they had to pursue this to the point where they got a clear message one way or the other before knowing what to do. In the meantime, Sushi wished to go to a homeopathic hospital they knew of which would provide care which was consistent with their cultural beliefs.

I asked when they would like this to happen. "Now" was the answer. "Would you like me to arrange it then?" "Yes please". Sushi then added, "When we are through with this I would like to come back and see you, I think I have a lot of things to sort through." (She never did). There was considerable relief within the family and I sensed that they felt as though they were back in charge of their lives temporarily.

I spent the next half hour locating Stewart, gaining his agreement as responsible doctor for arranging discharge, then getting the junior doctor on duty to arrange for medication and other formalities.

Some time later I sought Stewart out to debrief. He agreed to write to the senior surgeon in Sushi's Health Authority and ask him to write a definitive report based on information from all the specialists who had seen her. This would serve the purpose of bringing together all relevant medical information to inform any further decision-making about investigating possible physical causes of pain. Apart from that he showed no real interest in talking more about the case and seemed relieved that our part in it had ended so smoothly.

Reflections at the time.

I felt as though I had done little direct work with Sushi herself and that I had only seen a brief snapshot of the problems she and her family were facing. But I felt as though I had facilitated a process which at least empowered people to make choices. So what was this process? It seemed to me that I had visited all the different resource points in the department and connected together previously separate, or only partly connected, threads into some more meaningful pattern. I had facilitated the 'knitting' of this and felt pleased with the result. It felt that a slightly more robust garment had been begun. However, I did not feel I had a language to be able to explain this to my colleagues and felt therefore that my understandings would remain private.

I wondered why no one else had done this, had taken charge in the way which seemed necessary. My answer to myself at that time was that I was able to do so because I had developed a connection with the various groupings within the department, in addition to the client group, and therefore had access to their roles and views of the world in such a way that I could help make the connections across the groupings to deal more collectively with the presenting problem. I felt located in the centre of the department, not feeling as though I belonged fully to any one of the parts, but linking with each. This was an intriguing realisation to me but not one I could articulate easily to colleagues. I realised that this was one outcome of the process by which I had entered the department on first starting the job. I had wanted to 'map the system', learn what the elements were, how they changed over time, and how they linked with each other. This position I had occupied in working with Sushi seemed to be a 'niche' I occupied on my own and with that came a dual sense of connectedness and isolation/vulnerability.

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I much later discovered that I was seen as: "David is our psychologist but he does lots of other things" (on being introduced to a visitor by a physiotherapist who later joined the department); " David is the only one who negotiates admissions where everyone is clear about what is involved" (the ward Charge Nurse to William); " This is David, the only other psychologist I know who gets his hands dirty." (a colleague who runs a clinical psychology service to local Social Services children's' department, introducing me to her new colleague); "You do not work like any of the other psychologists I have worked with, you are much more pro-active and involved in things." (a senior nurse after having lunch together with several other psychologists). This was affirmation and lessened the sense of isolation. I was to discover also that it was not incidental that these were all women who had made these comments.

Commentary on these two stories.

Firstly, I would like to articulate further some of the growing awareness at the time of these two stories which is not contained in the reflections above. Then I will give a retrospective narrative comment as the researcher "I" creating this final research account.

Growing awareness.

In terms of what I learned for practice from these two stories at the time, I began to see more clearly what the issues were for dealing with 'complex cases'. Many of these could not be solved at the level of the individual client, but needed to be solved at a wider level of planning the 'patient journey'. In other words, looking at complex cases as a group or class, assessing what their requirements were likely to be, what resources and skills were needed, and what administrative and decision-making procedures were required to support the clinical process. At that stage, I was not sure how many of my clinical colleagues shared my frame about 'complexity'. Inquiring into this would need to be the first step. It is another story I will return to in a later section.

In terms of myself as a researcher at the time, I considered only that I could not see much use for Torbert's framing/advocating/illustrating/inquiring framework as I had chosen to apply it. In terms of his levels of development, I speculated about myself as being either an Achiever or a Strategist. I saw myself sometimes operating as an Achiever but borrowing from the strategist when I framed events in wider historical, organisational and social contexts. At other times I could see myself as operating in Strategist territory, working outside existing frames, and in so doing obtained a possible explanation of my sense of isolation and vulnerability. Torbert sees individuals operating at this level as being outside the frames of 'craft logic' and working beyond the outcomes expected within them. The contradiction inherent in Torbert's model of leadership is that as soon as one begins to think about levels of development beyond the achiever, there is no 'craft language' with which to talk. One is into the realm of many languages which are beyond the usual realm of discourse for professional practice in mainstream health settings.

In relation to his model of power, I speculated that there may have been elements of at least three types at play in these two stories. I considered that I had exercised unilateral power in Eddies case by refusing to play my usual role, but in so doing may have disempowered Eddie. I considered that there had been clear uses of diplomatic and rational power in my gaining agreement to do things a certain way by virtue of my dialogue and by making a 'rational' case in Sushi's story.

As for transforming power, I found it harder to speculate about this at that time. There were paradoxical elements of my style which would suggest a use of power or influence beyond the unilateral, diplomatic or rational forms as described by Torbert. In Sushi's story all the participants were feeling powerless and there was a clear text to 'do something'. I did something by supporting other staff in making her as comfortable as possible in the circumstances, but I also said 'let's do nothing' until we have sufficient information. This reframing enabled myself to do something I hoped would prove more effective in the longer term and had the interactional effect of lowering the overall level of anxiety (including my own). 'Doing nothing' can have the effect of allowing participants to transcend their immediate anxieties and become more aware of 'what else' is going on outside their immediate awareness. In Eddie's case I was clearly hoping for more 'just' processes and outcomes, but I felt that very little that could be described as transformative had occurred there.

I did not feel that the ideas from Torbert resonated much with my experience at that time. I recall starting to feel frustrated and angry with myself at that point. I remained preoccupied and muddled about how to begin a more public dialogue about how I was seeking to work, about how to bring practice into the domain of research. My perceptions at the time were that I would need to be able to exercise more authoritative forms of leadership if I were to begin a research project as I had envisaged it. I did not see myself as having or being able to use the influence I believed was needed. I was becoming more frustrated and confused at the

continued dissonance between researcher and practitioner, and I was not able to resolve this within the frameworks available to me at the time.

A narrative comment..

My journey at that time was to find a way of authentically beginning the research process as I understood it to be. My use of Action Inquiry strategies was secondary to this, a vehicle for finding a way forward and not my primary focus. Nonetheless I will make a brief retrospective comment here on my implicit and explicit use of Action Inquiry.

I am able to look back and see aspects of Action Inquiry present in the encounters which I could not apprehend at the time. Because of my frame about research as necessarily involving the explicit agreement and collaboration of others in use of inquiry strategies, I was blind to those aspects which Torbert (1981) describes as characterising an inquiring interpersonal strategy. For example, he warned that at any one time interpersonal inquiry was a more or less distorted and incomplete process in which paradigm clashes are to be anticipated (and welcomed as an opportunity to test assumptions). Therefore, it should not have been surprising to me that I encountered such a 'clash' in my attempts to consciously use his interpersonal strategy in Eddie's case. Also, a comparison can be made against one of Torbert's (1981) characteristics of 'experiments-in-practice': that the test of whether 'any given action is aesthetically appropriate, politically timely and analytically valid is whether it yields increasingly valid data about the effectiveness of any acting system.' Both cases offered such 'data' to me, one was about how to 'get it wrong' and the other about how to 'get it right'.

Furthermore, in Sushi's story there is considerable use of Torbert's framing/ advocating/ illustrating/ inquiring, but I recognise it as being implicit in my own personal style. The difference between the two cases regarding degree of success, in terms of Action Inquiry, is that in Eddie's case I accepted the existing dominant frames (although reluctantly) and attempted to work within them. I was not authentically inquiring into the frames held by others and not seeking to offer or 'co-create' alternatives until the end, at which point they were rejected. On the other hand, in Sushi's case I sought to inquire into the frames of all the participants from the outset, created a new frame within which we could all begin working together, then continued the 're-framing' as I went. This use of reframing can be seen as an exercise of a transforming power, and it is an issue I return to later in the journey.

A further difference between the two cases exists in the relationships between myself and the doctors. In Eddie's case I constructed the doctors as having more power in relation to prescribing and myself as being relatively power-less, and this construction had the effect of positioning me in 'supporting' care. Alternatively, in Sushi's case there was a shared agreement amongst all the participant's that prescribing would cease and hence there was no implicit struggles for control around its continuation, Instead, the doctors appeared to feel relatively 'power-less' in the face of her pain and distress and both invited and allowed me to

'lead' care. I did so in a way which was unexpected, and in a way which I felt unable to share explicitly because the frames within which I was operating were too far removed from those held by others in that immediate setting. However, in retrospect I can see in Sushi's case a greater degree of willingness among medical and nursing staff than I had experienced earlier in being prepared to move outside some of the implicit 'rules' and assumptions about patient care in the ward. Whilst I could recognise this a practitioner, I did not know how to transfer or translate into a research frame of reference.

Moving away from Action Inquiry and back to my journey of that time in finding an authentic mode of entering research, Sushi's story further highlights a contradiction. If this story alerted me to the increasing awareness I was placing on constructions of those involved in any one case, then this gives rise to some interesting questions: "Why were my own constructions about myself as a researcher not within the frame; what was it about my own self-awareness, my own practice approach, the research methodologies I was using which positioned me outside a consideration of how the constructions of *all* the actors were influential in informing action and creating meaning?; what 'stories' of my own were not present or given voice?"

In the next chapter I will present the process of how I was offered the beginnings of some answers to this question through considering the a feminist critique of social science and the role of gender.

9. GENDER AND A FEMINIST CRITIQUE - OFFERING A WAY THROUGH.

Introduction

The process I wish to describe now is not linear or smooth. It unfolds then folds back on itself, to and fro in time. It is a process by which I take a closer look at my own personal history and, in so doing, bring my personal experience more fully into the research field. The stories I have presented so far, the experiences I have reported and the sense I have made of them, both lead up to this period and also flow out of it. The journey I have narrated so far happened in the temporal order reported, but its inclusion in this research account in this form, with the interpretive gloss I put on it, happened because of the inward personal journey I will present here. It was the re-writing of aspects of my personal history, and the discovery that a feminist critique and a gender analysis had something powerful to say to me, that enabled me to take a discontinuous step forward. This was not only in my research but also in my personal and professional development. This new appreciation enabled me to see the events reported thus far as part of the inquiry process, as within the 'research field', and to feel more able to see 'practice as research' and 'research as practice'.

An Inquiry into the personal: rewriting history.

The dissonance between research and practice, together with the partially understood sense of vulnerability which I have commented on to date, reached a crisis point when I was required to produce a substantial piece of writing to transfer from MPhil to PhD status. This was to be read by fellow research students, supervisors and an internal university examiner. This created considerable personal tension. I considered I had failed so far to begin any research and that this failure was due to my personal inadequacy.

I had strongly resisted shifting the focus of research onto myself personally. It was all very well including the researcher's theorising and sense-making in the field of research, but as I saw it research was a primarily social process and it was self-indulgent to bring the deeply personal into it - research should benefit the participants and a wider audience, not just the researcher! I believed in the necessity for making explicit my values, frameworks, and beliefs about the social world. I had found it interesting and useful for my practice to write about my own reflections in action. After all, it was a basic tenet of new paradigm research and a cornerstone of the work at Bath that research should include the personal process of the researcher/s (Reason and Marshall, 1987). But I was wary about going beyond this point. It was 'my problem' and not a 'research problem'.

I had no clear understanding of what 'the problem' was which was blocking the research process. I was inclined to think it boiled down to 'not having enough bottle to take the bull by the horns' and explicitly invite colleagues to form some sort of collaborative research venture. This fitted with an old script I had about myself, that I tended to go with the line of least resistance, go with what was happening, go with what other people wanted. I recalled a

metaphor I had about myself in my early twenties, of being like a stream which found the easiest pathway through the terrain, afraid of forging into new territory or of taking risks. I did not see the possible strengths immanent in this metaphor, it was a critical self-evaluation about 'passivity' and one which was surfacing again in the context of research.

Although I had taken what others considered to be risks in my professional life, although I had risked disapproval and faced conflict, this was sanctioned because it was on behalf of others. Where I was concerned, I tended to see myself as having difficulty asserting, or even knowing, what it was that I wished to see happen.

I began discussing this more often and in greater depth with Jan, who was also having to prepare a transfer paper. Her approach was to ask questions about my earlier life, prior to beginning the research, inquiring into how I worked in previous jobs - asking questions about style of working, ways in which I accounted for what I was doing, and commenting on patterns in the past which seemed to be mirrored in the present. As a result of these conversations, I reflected on the influence of my life as a child - being virtually an only child with a sister who was away from home for most of her childhood in a school for the blind, considering the implications of the closeness in my relationship with my mother and the distance in the relationship with my father, and so on. This did not ease the frustration, nor my resistance to including all this as part of the research field, but seeds were sown.

Then, while at a writing week with fellow research students, exploring writing as a creative process, I began putting some of these reflections in writing. I intended as part of the transfer paper to give a summary of my readings of the literature and my attempts at beginning research, but first of all to honour the personal process aspects by giving an account of the values, theories and beliefs I was bringing into the research (I had already started doing this in my diaries, but they had been relegated to the back pages). As I started doing this, I found I could not punctuate where the 'story' should begin. I found myself taking steps back in time. For example, in writing about the influence of family therapy on my thinking and practice I found myself having to write about early professional experiences which led me into this area. Then, in doing that, found myself taking yet a further step back in reviewing my original training as a clinical psychologist. And so it went. I was "writing backwards" as I complained at the time.

Over the course of that week I wrote an autobiography of my life since leaving home to go to university. I traced the influence of family life and mapped the many transitions through tertiary education, from starting with engineering as a career choice, through several years of science, to exploring law studies and finally arriving at psychology. I re-visited the different 'pairs of shoes' I had tried on - hippie, Marxist Leninist, factory worker, tenants rights activist, leather craft worker, and so on. I looked again at friendships and intimate relationships over that decade.

I had previously seen that period of my life with a quiet sense of shame, as having 'mucked around', wasted time. I had seen myself as directionless, without a stable identity and as having given myself a 'slipshod' education. In the process of writing about this, I saw it through different eyes. I appreciated that what I now saw as assets in my life had been forming and taking shape over that time. I was more forgiving of myself. I saw how this period of my life was not necessarily discontinuous, that there were patterns connecting childhood ("good time") and the present which ran through this period. I had 're-written' my story of that time.

The process of writing was a deeply inward looking and healing one. It was also a recursive and emergent one. It was emergent in the sense that, despite intentions about what I wanted to say in writing, I would never know fully what meaning or slant would emerge until I had written. It was recursive to the extent that as new meaning emerged from writing, it informed and enriched the sense I made of the past and the present. It would then inform further writing and reflection, and suggest further action. Writing was no mere passive reporting of experience. It was active inquiry into the internal domain which generated new knowledge.

This gave me a personal licence to place myself a little more centrally in my writing as chief 'sense-maker' and to be more creative. It opened the way to experimenting more fully with writing in story form. It helped 'give life' to experience and to begin naming the voices in my internal dialogues around research. It began untangling the tangle. This in turn engendered a more curious dialogue with myself. The NZ stories in chapter three emerged in a more polished form from that week. However, it still did not show a way through my research-practice impasse.

I continued to wrestle with this as I prepared the transfer paper. On one occasion when I was feeling particularly blocked in writing I complained loudly to Jan. She suggested that we swap places and I talk about what ever came to mind concerning the research while she wrote it down. I began and quickly moved to talking about how frustrated and angry I was at some of the interactions with senior male colleagues in the department, particularly the two consultants. I talked of the difficulties I experienced in meetings where I felt the inquiry was one-way, where mystery-mastery strategies prevailed on their part, where cooperation could only be gained where there was self-interest, where blame was externalised, where everyone else but them was incompetent, where the only important agenda items were what they brought to the discussion. I talked about how I felt silenced by this, about how futile it seemed to confront this because I did not think they would be able to hear alternative viewpoints, about how I felt unheard unless I talked in their language, about how much I had to keep private my own views and experiences. Trying to join with them for the sake of the greater whole of the service seemed impossible. Either I felt 'holier than thou' if I gave voice to alternative and non-blaming viewpoints or, what was worse, I found myself sometimes joining with their 'us-against-the-world' attitude.

When I had finished Jan said: "That is how I feel. I have felt that way for years. For women that's a common experience. The only way I can manage is to try and carry both agendas - theirs, the public one, and mine the private one, where I am trying to make things work for everybody. The only time when I find it possible to disclose how I see things authentically is when it is on an issue which does not affect them at all. This is usually about taking care of patients as a nurse." She suggested I read several articles on women's experiences in organisations.

I began to wonder how my research fitted into this 'public' and 'private' separation. If my practice was about 'psychological treatment' in the usual sense, I was clear I would have no hesitation in discussing it with the two consultants and seeking their explicit involvement. We would have a language in common. Was it the case that my practice had a large element of 'taking care'? If so was this the reason why I hesitated. Had I intuited that they would have no interest, that they would in fact challenge my involvement in 'taking care' as not part of my job. Furthermore, it became clear to me that if this was the case, then they most certainly would not be interested in joining me in a research venture in which framings of practice as 'taking care' would certainly be present. It was the literature I read next which opened the way forward for me, and it is to this I now turn.

Dialogue with literature.

Before beginning my reading of the literature, it is important to place it in the context of my analysis of gender at that time. My knowledge of feminist theory was slim. It came from reading several feminist novels and from conversations with female friends and colleagues. I came into the research with the view that women's experiences and knowledge were different from those of men. Hence my understanding of feminism was based on the importance of respecting the difference. It was not men's place to arbitrate over women's experience.

This had a grounding in New Zealand society, where there had been a strong women's voice saying 'each to their own'. Many women were reserving the right to no longer be the emotional care-takers for men. There was a strong challenge issued to men to start taking responsibility for their oppressive behaviour. It was their place to confront their own violence to women, and it was their place to start taking care of themselves and each other. This was based on a belief that partnership was only possible after a separate development of masculine and feminine identities. Only women could understand women's experience and men could not call themselves feminist. Within this context I did little reading and had no contact with a feminist critique of social science. I came into the research with the idea that gender was likely to be an important issue in teams and organisations, but I was only seeing this at a social and political level, not at a personal level.

Women's experiences in Organisations: a feminist critique.

My first awakening came from reading a paper by Coleman (1991). She describes the use of a Cooperative Inquiry approach to investigate women's' experiences in her own organisation.

Her starting questions were about women and the extent to which, and the way in which, gender affects organisational members experience of work, the meaning work had for them, and the meaning they have for the organisation.

She starts from her own position as a postgraduate research student beginning a piece of research within a university and experiencing a disjunction between the knowledge publicly accepted as valid by the organisation and her own internal or private knowledge which she felt was not validated or allowed a voice. Rather than "problematise" this experience, she places it in the context of the organisation being gendered. Hence propositional, disembodied and objectified knowledge is legitimised, but at the expense of experiential and practical knowledge (Heron, 1981).

A further disjunction or incongruity for Coleman was that the 'university course-as-organisation' engaged in discussion and analysis related to the world beyond but not about processes related to itself. In this way only a 'partial' reality was created for participants. These incongruities generated a sense of discomfort which her gender awareness linked to those feelings of inadequacy and voicelessness which many women report in joining educational or work organisations. Rather than assigning this inner reality to the domain of a private problem, which ensures gendered stereotypical framings of inadequacy, subjectivity and emotionality, she decided to make 'her problem' a public 'problem-to-be-investigated'. In other words, her research would start from the basis of her own experience , and in turn would include that experience in the field to be researched.

Coleman takes her warrant for this position from a feminist critique of science in general, and of organisational theory in particular. I will summarise these positions as she describes them, and as shaped by my subsequent understandings from further reading and experience. It is difficult to summarise what is essentially a pluralistic viewpoint, but for my purposes here I wish to take an essence which grounds my further interest in the area.

• A Feminist critique.

Broadly speaking, feminist writers have developed a critique of mainstream science which contends that it is not the only possible way to go about understanding the world (Spender, 1981; Stanley and Wise, 1983; Eichler, 1988; Rosser, 1988). It is only *one* way, and one which occupies a particular place in history. It is patriarchal , and an example of how this is reflected lies in the dichotomising of experience, where the objective is greatly valued over the subjective. Use of objectified knowledge permits the development of hierarchies of expertise, where those who 'know' are able to judge the experiences and actions of those who 'don't know'. This is one way in which domination is sustained.

Feminist voices have in common their challenge to the patriarchal representation of what is known. They seek analyses of experience which take into account the underlying power relationships and the particular ways understanding is managed. Their starting point is 'felt experience', and through analysing the political dimensions of that felt experience, seek to

validate that experience and reframe its usefulness for those whose experience it is. This starting point gives rise to the contention 'the personal is political'.

This contention is based on the assertion that women's everyday lives, because they are largely conducted in the private rather than the public sphere, have been largely omitted from accounts of history, from political theory, and from more general accounts of culture. Therefore, the world is largely constructed in male terms through male eyes. The resultant reality is at best 'partial'. Daly (1978) maintains that women have had the power of "naming" their experiences of the world taken from them. Their experience is named by men in terms which constitute a "language of theory" rather than a "language of experience".

What feminist writers have in common is their challenge to the probable genderedness of current representations of what is known. They proclaim there are alternative accounts of the way the world is and the starting point for building these accounts is felt experience. (I note here that there is much continuing debate about the problematic links between sex and gender e.g. Connell, 1995).

In applying this critique to organisational theory (e.g. Mills, 1988), Coleman finds limited help for her purposes. She find little in what is essentially a sociological analysis which gives a space where the individual can exercise agency in developing theory and a practice based on experience, and which at the same time helps bring about change. While she finds a feminist critique of theory lays out principles for knowledge building, she finds little is said about how this is translated into practice. For this reason, she chooses Cooperative Inquiry as a means for investigating her own and her women co-researchers' experience in their own organisations.

• The implications for myself.

It was not so much Coleman's use of a feminist critique, important though that was, but rather her experiences and those of her research participants which leapt out at me initially. These spoke directly to my own experience, and echoed my conversation with Jan. The metaphors describing the experiences of participants in the research mirrored my own. Those of 'muted voices', 'silence' and 'invisibility' captured how I felt in relation to exposing aspects of my practice and my thinking. The concept of organisations being gendered, of valuing and reflecting those qualities of experience and knowledge which are historically male and patriarchal, struck me forcibly at an experiential level. I suddenly could name my experiences in way which took them out of the domain of 'individual problem' and place them in a social and political domain in which I was not alone.

The researchers' stories also spoke to my current experience in attempting research. If organisations are gendered, and if I felt silenced as a researcher who wanted to speak out, did that mean my work was also gendered, located in the domain of female or feminine experience. I wondered whether a feminist critique went beyond gender and applied to any situation where there were dominant 'realities' at play which obscured minority and private realities. Or, was the over-arching construct one of gender, where in fact such a hierarchical

arrangement of 'what is known' is a representation of patriarchal arrangements which go beyond culture.

At the time of reading this, I felt liberated to read more feminist literature, and to consider the role of gender in understanding my experiences. I realised how my earlier framing about gender, as a political domain in which I respected difference, had precluded me from seeing the implications for myself in my personal domain. I now realised that a feminist perspective had something powerful to say to me at a personal level. This left me very interested in gender, in the differences between male and female experiences, and in how this could apply to my own experiences. I turned to literature about gender, starting with what constituted 'masculine and feminine'. I was intrigued with the idea that there was a link between those aspects of myself I had 'problematised', my practice, and notions of 'the feminine'. For a start, I wanted to understand more of the 'feminine'.

The Masculine and the Feminine.

I had been starting to read some of the new popular 'men's literature' about the contemporary 'masculine' (Keen, 1992 and Bly, 1990) but had not been very captured by it. I did not find anything particularly transformative for me there. I felt I needed a more thorough grounding of the notion of the feminine against which to understand the masculine, and hence their relationship with each other.

Colgrave (1979a) draws on several different sources to describe masculine and feminine principles. The idea of these as polarities separate-from-but-deeply-inter-connected-with each other is embedded in mythology and eastern philosophy (e.g. Yin-Yang theory from the 'I Ching') and more recently has been articulated in western analytic psychology (e.g. Jung and Steiner).

Jung holds that psychological maturity requires a relationship between the masculine and feminine aspects of self. This is a "sacred marriage" central to many religions and philosophies and is the highest form of psychological development which cannot take place before the complete differentiation of the masculine and feminine from each other.

Yin-Yang theory argues that there are two cosmic principles inherent in all phenomena and responsible by their interactions for the emergence and dissolution of all things. They are expressions of different parts of the one continuum or the one principle, the Tao, behind all creation. By its very nature the Tao is beyond definition. This theory has been elucidated and developed within western culture by analytic psychology.

Colgrave points out that the formulation of Yin-Yang theory could not have taken place without the birth of the masculine principle and the polarity in consciousness it created. She then draws on mythology which speaks of a time of pre-polarised consciousness when everything appears to be embraced in one undifferentiated unity, where masculine consciousness has not yet emerged or been born in order to split human awareness into subject and object, mother

and child, male and female. This polarisation of consciousness allows for the emergence of a feminine principle whose salient characteristics are those of recognising and helping to create relationships, of being receptive and recognising harmony.

There are inherent dangers however of exploring and developing one polarity without the assistance of the other. While an awakening of the masculine principle is necessary for a sense of self, of independence and ability to discriminate, too much of this at the expense of the feminine can lead to isolation, loneliness, rigidity and despair. Similarly, the feminine provides attributes of listening, yielding, nurturing, accepting and trusting, which allow for relationship to inner and outer nature, but without relation to the male principle may lead to loss of self and undifferentiated chaos. These principles, according to Yin-Yang theory, underpin all aspects of life.

Colgrave describes the concept of Androgyny as a way of conceptualising a psychological union or marriage of the masculine and feminine, in which both are equally valued. The product of such a union would be the birth of a new sense of self. Within the concept of Androgyny, such a marriage would produce also a tension between opposite poles; between a search for knowledge and freedom on the one hand, and wholeness and peace on the other. This propels the individual ever onward in a journey toward a state of being in which understanding and peace are no longer in conflict.

In looking anew at my work, the idea that the construct of organisation itself was masculine, and hence excluded feminine knowledge, assumed a personal relevance. It seemed a gender analysis offered another way of understanding the incongruities between organisational processes, my work and research, and myself which liberated me from a self-blaming stance and opened up alternative possibilities. While I was not clear at that stage what these possibilities were, it was clear that this was something I needed to explore more fully and take more awarely with me into the research.

The idea of organisation as a construct without an independent reality seemed to link into further feminist critique relating to wider organisational structures. Pringle and Watson (1990) for example, theorise the state not as an entity but as a set of arenas or a collection of practises constructed by "fraternal discourses", super ordinate to organisations, families and individuals. They see the state as a site for the construction of meaning. This theorising leans heavily on Foucault and his development of the analysis that meaning is constructed and managed through discourse (e.g. Foucault, 1980). Hence links were made back into psychology for me, in that social psychology increasingly uses the discourse analogy. I will refer later to Foucault's analysis of power when reconsidering my relationships to power and gender as an outcome of this research venture.

It is important to note here that while I enthusiastically pursued the idea that there were masculine and feminine principles at play in the world, I did not pause to examine how those were arrived at. Later reading and experience revealed problems in this area. As I have

already noted, the link between gender and sex is problematic and currently debated. There are wide differences in individuals' experiences of gender according to social and cultural conditions. In addition, such polarities run the risk of continuing gender stereotypes and are based implicitly on essentialist or foundationalist assumptions that there are dimensions of gender which are beyond history and the social processes by which they are constructed (e.g. Connell, 1995).

However, at the time, this was precisely their appeal for me. Through these constructs, I felt connected to some deeply patterned aspect of life which was enormously satisfying. At this stage I became excited about developing my ideas on masculine and feminine principles in a way which allowed for a more holistic view of myself as a man, and which also honoured both differences and similarities between men and women while acknowledging existing differences in power relations at a social level. I found these in Marshall (1984).

Gender and relationships

Marshall starts from her interest in understanding the issues for women in relation to management jobs. She seeks a framework for understanding gender, and the relationships between sexes, which is free of those values which devalue either sex. I shall summarise the important ideas which stood out for me at the time. These ideas come from the key theoretical offering in her work in which she borrows from Bakan's (1966) analysis of Agency and Communion in order to develop her own model of male and female qualities, in a framework of potential equality and relationship.

In developing her analysis, she reviews literature which addressed both the personal and the political, drawing upon explanations from individual psychology and sociology. She draws attention to the role of language as a fundamental element of culture which reflects, perpetuates and shapes our values and consciousness. Women are rendered invisible and undergo a semantic derogation by language which takes male as the norm. They must emerge out of a translation process which converts their meanings into male forms of speech in order to express themselves in socially understood and accepted terms. For example, Olsen (1978) calls this process "telling it slant". Not to be able to express one's own truths "robs one of drive, of conviction and limits potential stature" (p.51).

Marshall also reviews notions of social power which offer an explanation for how the pattern of inequality between the sexes is maintained. For example, she considers sociological analyses of how the complementary interrelationship between dominant and subdominant or muted groups is maintained. She seeks the seeds within the dominant-muted construct for an equal valuing of different characteristics between male and female, but finds instead implicit and unexamined assumptions which derive from a male view of the world. In addition, much sociological theorising is at the political level and leaves little or no room for individual motivation or experience. Still seeking an explanation which extends into individual men's and women's lives and gives equal worth to non-equivalent characteristics or social positions, she

draws upon Bakan's theory, also used by other feminists (e.g. Reinhartz, 1981). While there was much of importance for me in Marshall's analysis to this point, I was looking for something which spoke directly to my own experience. I found this in her rendering of Bakan's twin concepts of Agency and Communion. I will briefly summarise the key points I wish to take, before commenting on their importance for me.

Agency and Communion.

Bakan proposes the concepts of Agency and Communion as twin styles individuals use to resolve existential questions of being and not-being, of independence and interdependence. They can be seen as coping strategies for facing the fundamentals and the anxieties of being alive, and Bakan distils these from religion, analytic psychology, mythology and philosophy of science. Agency is the expression of independence through self-protection, self-assertion, and self-expansion while Communion is the sense of being at one with other entities. Together, the two styles are potential complements. I will summarise the characteristics of each separately.

• Agency.

The agentic strategy's main aim is to reduce tension by changing the world around it. Agency is manifest in characteristics of focus, closedness and separation and achieves its aims through a series of stages. It is the style associated with the concept of ego, and with the individual's transactions with the external world. The underlying principles are the achievement of control through separating good from bad, and repressing the bad by, for example, projecting the bad qualities onto the external world. The agentic uses knowledge to instrumentally act on the world around it and in that way seeks mastery. However, this leaves many uncertainties beyond control, rendering the sense of mastery vulnerable. Hence denial is used to cope with the anxiety thus caused. The means of transcending this contradiction between mastery and vulnerability, and coming to terms with the anxiety is through 'healing. This is achieved through 'beholding' what has been repressed or projected, fully encountering it and reuniting the previously 'bad' . The 'split' is thus 'healed'. In this way, understanding is substituted for control, and paradoxically the suspending of mastery results in a more profound mastery.

• Communion.

This is not characterised by separateness or stages, but rather, functions all at once. Its main strategies for dealing with the world are acceptance and personal adjustment. It seeks union as opposed to separateness, and its perceptions are not based on prior analytic classification but are naturalistic, reflecting the nature and patterns of its environment. Communion's openness to its environment produces intense personal impacts which contribute to richer understandings. It accepts the good and the bad and willingly adapts to circumstances, considering change natural. Following is a summary of the characteristics of both Agency and Communion as life strategies.

• Summary of characteristics of Agency and Communion as life strategies.

	AGENCY	COMMUNION
Main Aim	Control	Union
	Independence	Interdependence
Dominant Strategies	Assertiveness	Cooperation
	Control	Contact
	Change	Openness
		Acceptance
		Personal Adjustment
Characteristics	Doing	Being
	Egoic	
	Formal Organisation	Tolerance
	Physical Action	Trust
	Classifies, and projects classifications onto the environment	Naturalistic perception of environment: emphasis on wholes, patterns, relationships, contexts
	Distance	Emotional tone
	Contracts	Non-contractual cooperation; forgiveness
	Change-resisting	Contextually motivated
	Achievement -oriented	

From Marshall (1984).

• The implications for 'action'.

Marshall conceives of action from within the two domains in the following ways. Agency engages in idealisation and tries to change the environment to match its own preconceived images. Doing is directed by internal, personal objectives. Communion is not inactivity by comparison, but its activity emerges from radically different roots - from its open contact with and appreciation of the environment. Action is mainly context-motivated. Prior acceptance of the world-as-it-is results in action which is in tune with the surrounding context, but is not conceptually premeditated. Therefore, action based in the communion may be highly appropriate as a result, but it also risks being too thoroughly shaped and determined by the environment.

The agentic mode interprets the world as its product because of the deliberate intent involved in its doing, and the principle of independence on which it is based. From its perspective, 'success' is demonstrable and individual. In contrast, communion sees itself, and even its actions, as part of a wider context of interacting influences. It tends not to assume personal accomplishment when events turn out favourably.

• Agency and Communion in relationship.

Agency and Communion have their degenerative tendencies as well as assets and I will present them in turn.

Degenerative Tendencies. The inherent qualities of each shape their relationship towards non-equivalence and inequality. Agency's insistence on control has profound effects. The distinction of communion from agency is itself a function of agency's attempt to suppress and deny the experiences of open contact with the environment which threaten its control. Agency therefore tries to repress the attributes of communuion from which it has originally separated itself.

Through its own activities, agency creates around itself a world of competition within which it is naturally the dominance seeking style. In relation to agency, communion's cooperation seeking strategies are effectively complementary, but fated to submission rather than equality. Acceptance of the environment becomes subjugation rather than mutually influential union.

Degeneration of agency occurs if threats which have been suppressed to achieve control are not later recognised and re-incorporated. Instead, action on the environment is often interpreted as successful, and any conflicting evidence such as unintended consequences or other peoples' disagreement, are ignored (e.g. pollution of the environment). Over-control can also unknowingly damage elements of the context or its patterning whose importance were not originally appreciated in the narrow perspective taken.

Communion's strategies make it open to penetration, flooding and eventual destruction by contextual forces. The nature of its environment affects communion more than agency. This vulnerability is accentuated because communion has no strong base of self-worth from which to sustain itself - its attributions of success are also context dependent.

Assets. Each deals with uncertainty and anxiety in its own way and can be highly successful in appropriate circumstances. Agency's main achievements come from thrusting out into the unknown, pitting wits against environmental forces, imposing order on chaos. Communion's triumphs are by nature less tangible and come from integrating, reconciling, synthesising, and supporting the flow of events.

Either pattern alone runs the risk of an over determined pattern, robbing the individual or social group of flexible strategies for coping. But the use of the two *in synthesis* offers a broader base of potential coping. Marshall suggests by way of example that a professional who uses a dominant approach of control runs the risk of creating too much client dependence and possibly even antagonism. At the other extreme, she suggests, exclusive use of a communal strategy may confuse expectations the client holds about expertise, and provide too little structure to contain both parties anxieties.

• Implications for personhood and identity.

Marshall identifies potential links between agency and communion, and male and female sexuality respectively. She proposes that these links provide a potential pre-disposition which act as a grounding for later development. She then follows several lines of tentative inquiry towards notions of identity. Firstly, she explores the implications for communion as a female disposition. Social norms idealise a strong sense of self-identity, self-esteem, independence and confidence. These underpin commonly held notions of 'healthy development'. Marshall sees these as agency based and hence male-grounded. In these terms women are more likely to be viewed as 'dependent' and 'weak'. In contrast, some feminist theorising holds women to have 'relational' identities (e.g. Gilligan, 1982) - that is, women see themselves more in relation to others rather than via a strong sense of self. Viewing this alternative as an expression of the communion principle gives it a positive connotation.

It is possible to see the conceptual distinction between agency and communion as a reflection of the agentic. This, she speculates, offers a possible model of male as a differentiated organism in which one part has been actively repressed. From this perspective it is possible to conceive of female as communion and agency in unsplit wholeness. But this very conception makes it difficult to capture in analytic, distinction-making language.

Marshall draws from several sources which suggest that the female principle is dual in nature and concludes that it is likely that women have free access to both the communal and the agentic strategies of being. This conception is reflected in the experience of those contemporary women who seek satisfying lives through both motherhood roles and challenging paid employment roles. Such a mixture of roles reflect both relational and independence needs, and women typically portray them as part of an indivisible whole.

Drawing these strands together, Marshall suggests a model in which communion is women's dominant tendency, but is twinned with a more or less fully developed agentic auxiliary. This is a more viable combination for women than the alternative pairing of a dominant agency with an auxiliary communion. Agency will tend to repress alternative modes to gain control and make this an inherently unstable pattern, whereas communion will be tolerant of and accepting of supplementary tactics for coping. She sees several functions for agency as an auxiliary to communion for women.

- Providing protection for communion's vulnerability in hostile or new environments.
- Creating structures within which communion can operate.
- Supporting communion by giving it direction.
- Affording a systematic understanding of alternatives within which communion can locate itself.
- Helping translate communion into direct effects through judicial instrumental action.

Marshall has an image of a positive direction for women "based in who they have been and are,...of communion enhanced, supplemented, protected, supported, aided, focused and armed with agency." (p.73)

Bakan's suggestion to men would be his paradoxical healing stage, relinquishing control to gain better mastery of what threatens them. Men need therefore to suspend stereotypical perceptions of the world, together with the judgements which accompany them, in order to perceive clearly and encounter what is. Only by mitigating agency by communion will this be possible.

Marshall places this speculative model alongside others to deepen her new description of alternative possibilities for women. One of these is the concept of Androgyny, and she identifies two broad traditions in the literature. One emerges from myth and symbolism, often via Jungian psychology, portraying androgyny as a holistic and mystical realm of possibility. This tradition can be seen as derived through communion as a process of sense-making. At the other extreme, androgyny is portrayed as dissected into parts, categorised, defined and prescribed. Such a portrayal can be seen as a hallmark of agentic thought processes.

Singer's (1976) 'Creative polarity' is such a communion-based approach. It is a mode of being characterised by 'the embracing of and easy flowing between one's masculine and feminine sides, whether woman or man.' Similarly, Colgrave (1979b), drawing from mythology and Chinese philosophy, interprets androgyny as 'the realisation of a self which is both differentiated and united'. Each of the unities must carry equal worth and be valued for the unity they imply rather than for the differences they reveal.

Writers in the area emphasise that the two principles must be distinct and clear in order to unite in this way. Bardwick (1979) is cited as an example. She sees gender identity as a critical existential anchor without which individuals would be unable to achieve a satisfactory sense of self or identity in relation to others. In this sense, androgyny would involve claiming the power of one's own gender and drawing on the characteristics of the other. Marshall links this to her notion of communion enhanced by agency, and agency mitigated by communion.

However, Marshall is disappointed with attempts to develop the notion of androgyny further. She finds Colgrave's analysis shed's some light on this. Colegrave depicts early matriarchal

consciousness as an integration of humanity with the universe. People were communally rather than individually motivated, free of ego consciousness. Although in this order there may have been greater equality between the sexes, and greater harmony between people and nature, there was correspondingly little freedom of choice, individuality, understanding and control. There may have been no oppression of one sex by the other, but there was also no real possibility of relationship. Only through the overthrow of matriarchal consciousness by the emergence of patriarchy could the male and female principles emerge as distinct unities. However Colgrave cautions that the subsequent emergence of a fully developed female principle has been overshadowed and constrained by the male principle.

Marshall shares this concern and she warns that until we have adequate conceptions of the female, interpretations of androgyny will tend resolutely toward the agentic. More radical inquiry into the female principle is yet required, and this will benefit not only women but also men. "Only through such developments can men enhance their appreciation of the male principle in dialectic development with its complement". (p.86) Within the alternative formulation of agency and communion, to combine productively the two strategies each need to retain their clear and distinct identities. Compromise debases their qualities. The ways of communion, like those of the female principle, currently require the focus of attention in order to remedy previous neglect.

Lessons through a 'Gender Lens'.

I connected strongly with the above strands I drew from my reading. I became aware that previously I had been locating myself outside my own theorising about the world. I had not been operating in a fully reflexive manner, but had been excluding my own personal process as separate from my sense making about my work. I now had a way of placing myself centrally in my experience, using a masculine-feminine/agency-communion set of spectacles. Through these I could better understand incongruities between myself and my environment, within my environment, and between the different ways of knowing within myself. I could now entertain all experience as potentially relevant in a rich way which had not been available to me previously. In other words I could allow the feminine/communion to value and incorporate the vulnerability and the not-knowing rather than exclude it in a masculine/agentic fashion.

I felt this new appreciation addressed important issues of authenticity which had troubled me to this point. If my sense of authenticity was in some fashion connected with a need to be able to account for how I knew about the world, and acted in the world, I realised I had not been fully present in this accounting. Major aspects of my experience, of my sense of self, had been in the back row, barely visible and muted. I wondered if I would have to revise my conditions for authenticity. Perhaps accounting is a masculine/agentic quality which has its uses in certain contexts. But perhaps there are experiences which are beyond language and naming, deeply embedded in the feminine/communion and therefore not available for a public accounting to others. Perhaps such experiences in certain contexts need to remain private,

protected and sheltered but nonetheless acknowledged and valued to oneself, not shunned. Being able to name this domain to myself in a more powerful, hopeful and positive way took it out of the realm of the 'problematised' and into the realm of valid and useful experience. I could be more fully present in my own experience.

I could now forgive myself my wariness about setting up a Cooperative Inquiry group in the midst of a culture dominated by the mystery-mastery strategy. And conversely I now criticised myself for expecting that women on the staff might join with me in such a venture and make themselves even more vulnerable than I was.

I could now be fully present in the research and I could authentically research how it was I functioned as a psychologist because I had found a framework which authorised this at a propositional level and also spoke powerfully to me at an experiential level. Although I came into the research with questions about how I functioned as a psychologist, I had not felt it legitimate within my existing world view to place myself at the centre. This had seemed selfish and individualistic. A feminist critique now allowed me to do so, although not in an individualistic or solipsistic manner.

I could see more easily now how practice and rigorous inquiry could be intertwined. I now valued my inquiry to date. I had unawarely been in the grip of an agentic and masculine view that research should always be public, and represent action, success and achievement in terms valued by the dominant culture. I had chosen an imagined masculine and agentic 'researcher audience' to whom my masculine/agentic self wished to account. I now no longer felt compelled to do so. I felt I had choices. I had another researcher audience which would respect the feminine and the communion.

It became possible for me to see that my tentative inquiries to date constituted research, and I could now also see how research and practise could be more easily be made interchangeable. I could make sense of the extent to which much of my work had been located within the realm of communion. I could see how major aspects of the research methodology I had been grappling with seemed located in the realm of agency to the extent that it required considerable agency to initiate it. Hence this accounted for the disjunction between practice and research method by which I had felt disabled.

I could see much of my practice as being an interweaving of the masculine and the feminine, agency and communion. I could understand more my work with Sushi for example. Those aspects which I could not name in that setting were to do with feminine/communion qualities of acceptance, seeking contact and cooperation, being prepared to not act immediately, to understand in context, and seeking pattern. I did not see my self as a causal agent taking credit for change.

On the other hand, I could see that these communion characteristics were interlinked in my practice with alternative masculine/agentic qualities of taking control, facilitating change in the

environment, implicit and explicit contracts, wishing to achieve, asserting my viewpoint in order to provide a structure for the encounters, and a belief that my actions would make a difference. These latter characteristics, masculine and agentic, were more visible and could be more easily named and accepted in my work setting - indeed, would have been expected.

In thinking about these new possibilities, I was not sure how they would translate into future practice. I found myself alternating between two positions, which I wrote in my reflective diary at the time.

> "At times I have a strong sense that residing too strongly within communion when thinking and reflecting about my research leads to feeling flooded and not knowing where the edges are. One conscious strategy therefore could be to locate myself within agentic principles and see where that takes me, perhaps returning to communion to notice or reflect. Perhaps the paradox is that by adopting this seemingly artificial distinction and holding myself within the one will allow me to better understand/sense/intuit/experience what the interrelationship is and how it flows. This feels very challenging and I am sure I will not be able to keep hold of it for too long (is this communion, reminding me of her presence already?)
>
> At other times it feels right at this stage to give more voice to the feminine, trusting that my essential masculine will prevent me from being swamped in the process (and noting that this act of drawing distinctions is an exercising of the masculine principle). By valuing personally and publicly the feminine principle in myself, my work and research, I am freer to let the masculine speak as well, (trusting the feminine to guide me in knowing when it is timely?). This approach has a wider contextual appeal because it seems possible that by valuing the feminine in themselves men can then come to equally value women and engage with others and nature in more respectful nurturing and holistic ways. This feels to be merely a starting place, accepting 'both/and' and accepting that I shall probably move to and from between."

A feminist critique had given me a warrant to include all my experience in the field of inquiry as potentially relevant. As a result, I could approach research as I did practice. I could 'go with what there was' and take that as the starting point. I could approach it from being located in communion, finding a form which 'fitted' naturalistically with the environment instead of seeking to impose a previously chosen form as I had to date.

This was what I chose to do. I could not be explicit to myself about what particular aspects of masculine-agency/feminine-communion I wished to take forward in a purposeful way. I decided therefore to pay attention to the pattern of interplay between the masculine/agentic and the feminine/communion, with a particular interest in exploring the presence of the latter.

SECTION THREE OVERVIEW.

This section covers events over a two year period which I see as the second phase of the research. During this time the department faced many rapid changes and there were many issues which were potentially within the research 'field'. I continued to keep field notes of conversations and observations, to keep reflective diaries and to write more crafted and 'storied' accounts of incidents which offered potential for inclusion in the research. I ended up with large amounts of data which gave rise to the question 'which stories do I include in the final research narrative?' By the time I came to answer this question, I had encountered Clandinin and Connelly's (1994) Narrative Inquiry framework and so used it to help analyse the data I had collected. I looked for patterns, threads, tensions and themes within my own experience and across the field of research which suggested 'which stories' to include and 'what shape' the final research narrative should adopt. To aid me in this I referred to the set of narrative criteria for rigour and quality as described in Chapter Two and took four criteria which I saw as helping me in my task. These helped me identify the narrative thread I needed to follow through the field of research.

- Stories are about moments or processes of challenge, growth and transition, and the meaning taken from them is presented in the research narrative.
- The purpose or the 'why' of the inquiry is present, either implicitly or explicitly, in or around the story.
- The author's presence is discernible in terms of voice and signature, and the framings from the different perspectives of the multiple "I "s are explicit.
- The research text shows an aliveness to silences or absences or stories not told and the possible meaning to be taken from them.

I started the phase by keeping the focus on the 'management of complex cases' as one which potentially held the research questions I was asking. Initially, nearly all my field notes, diaries and stories were about or around this focus. I worked with one particular 'complex case' over the two year period (Rosemary's story) in which I learnt much and which I used as an 'exemplar' in working with colleagues in more explicitly developing 'good practice' guidelines. However, the complexities of relationships within the department required that I eventually move away from this focus in pursuing the 'whys' of the research. The narrative thread moved to my relationship with the two consultants and in the chapters which follow, the reader will notice that Rosemary's story fades into the background. The reader will also notice that my voice becomes faint at times in my stories about working more closely with William. This fading is a metaphorical representation of my experience at the time, but it led to moments of challenge and a transition in my relationships with the consultants.

Using the above criteria to analyse my data allowed me to construct a narrative which illustrates two patterns of relationship between myself and colleagues. These two patterns together led me to re-conceptualise issues of power and how they influence relationships. The first pattern is myself with others with whom I feel there is openness and a willingness to develop mutual recognition and collaboration, but within the context of an implicit hierarchy of expertise in which I am seen as having this to offer and in which I feel comfortable offering this. This becomes manifest as I work with the 'downstairs' staff in developing a more explicit and systematic body of practice with 'complex cases'.

The second pattern is where I am seen as having expertise and in which I am prepared to give this, but find myself in a relationship in which it is difficult to achieve a mutual recognition and collaboration. In these relationships I see the other as having power I do not , and I expect them to use it wisely and am disappointed. I usually do not confront. In pursuing this pattern I come to learn of a 'life script' which influences my relationships, particularly with men. This pattern becomes manifest in working 'upstairs' with senior staff.

I finish this last section with a chapter reflecting on my learning from the research.

10. SETTING THE SCENE FOR FURTHER INQUIRY.

Introduction

In this chapter I will be 'setting the scene' for further inquiry in two ways. Firstly by describing and commenting upon further developments in the work setting as I saw them, as providing a 'backdrop' against which I make sense of my further inquiries. And secondly, by outlining the methodological issues I saw as relevant to my purposes.

At this point in the research, I needed to reconsider methodological issues for subsequent inquiry. My new set of lens provided by a feminist critique and a gender analysis enabled me to place all my experience within the field of research as potentially relevant to the questions at hand. I was now able to see the inquiry into my own practice as 'research proper' and not 'merely practice'.

The immediate effects of this with respect to methodology were twofold. Firstly, I was able now to accept more easily that Cooperative Inquiry did not need to be the only methodological framework available to me. It still held its original appeal but I was more accepting that the current circumstances did not lend itself readily to its particular form of inquiry. I still harboured ideas that I may use it in the future, but I was more relaxed about the notion that there needed to be a greater degree of mutual receptivity or 'fit' with the environment. I reserved it as an option for the future.

Secondly, Torbert's earlier ideas from Collaborative Inquiry (Torbert, 1981) became more relevant as a guiding frame for continued inquiry into practice. I had previously seen Torbert's ideas as speaking more to practice than to research. Now that I had a less compartmentalised and more mutually intertwined conceptualisation of the relationship between inquiry and practice, which was now more thoroughly grounded in experience, I saw his strategies for inquiry as having more to say to my purposes as a researcher. Using my 'fine print-bold print' analogy, what had previously been fine print now became bold print.

As a practitioner I believed my colleagues and I needed to move beyond individual cases and consider how we could develop more systematic ways of working with complex cases as a group. In other words, we needed to develop a more widely shared appreciation of the issues at hand, and gain some closer agreements about how we needed to work together to meet the needs of complex cases in a way which allowed for growth and change for all concerned.

'Sushi's story' had made explicit to me the degree to which different staff groups in the department had differing perspectives on the work they did with any one client. The role

I had seen myself playing in this case was to visit the different groups in the interests of getting sufficient integration or interweaving of views, which in turn allowed for actions which supported both stability and change.

As a researcher, I wondered what methodologies could support this process. Collaborative Inquiry offered a framework for an inquiring interpersonal strategy at an individual and an organisational level. However, at an organisational level within my own department I saw many limitations. There seemed little possibility in the short term for development of the type of consensus Torbert (1981) advocates as being necessary for the beginnings of a Collaborative Inquiry, where the initiating actor-researcher and other participating parties need to come to share the aims of a Collaborative Inquiry and the model of an interpenetrating attention span. I could see possibilities for collaboration with certain individuals, but not across groups. Given the difficulties I had experienced so far, I could not see such a diverse group of individuals easily agreeing to develop a consensus about either the nature or the importance of researching the 'management of complex cases'. I believed that I would need to be the person who moved across the groups and held any threads of inquiry initially, as I had in 'Sushi's Story'. I needed a framework to help me manage this as a researcher. This was offered by Guba and Lincoln's (1989) Hermeneutic Dialectic Process which I will describe below.

It is ideas from Collaborative inquiry and from a Hermeneutic Dialectic Process I wish to present here because they provide two guiding frames for subsequent inquiry reported in following chapters. I did not hold these frames in the same way as in Eddie's story, in the sense of holding them in the foreground of awareness with the clear intent of applying them in action to explore their usefulness. Rather, I held them as one of many frames available to me, noticing when they came from background to foreground to aid in making sense of complexity and in informing action. I was not only a researcher but also practitioner, permanent insider and member of the department, carrying many different aspirations and agendas. My experience so far had taught me that I could not be prescriptive ahead of time about exactly how I would implement an inquiring strategy while at the same time being alive to complexity and multiple opportunities and risks.

The development and the refining of an inquiring strategy was a more emergent and discontinuous process, one I note now but which I learned about experientially over the course of subsequent inquiry and will reflect on at the end. I will turn first to developments in the work setting then to methodological issues.

An 'update' on developments within the department.

By now the Mental Health Unit had become a self managed NHS Trust and had clearly separated from the local Health Authority. We were a provider unit and they were

purchasers whose job it was to assess the health care needs of the local population and commission services to meet these. Similarly, other health districts were now in a position to choose whether or not to continue using our service - they could purchase a tertiary specialist addictions service elsewhere, or alternatively could redirect funding within the district to other services.

It soon became apparent that some districts were not going to enter into contracts with us. Some because geographical distance and difficult transport links precluded this, others because of a history of conflict between local providers and our department. Some of the latter perceived us as not being responsive to their views of what was needed. At this time, both William and Stewart believed that they knew what these districts needed and were critical of how services were organised within them. In several instances this led to overt conflict between the consultants and their consultant equivalents in smaller local services.

On the other hand, several of the senior nurses had regional roles in linking with those services from other districts, providing consultation and support to workers and facilitating liaison with our department when a referral to us was needed. They found themselves the 'meat in the sandwich', trying to work between the views of the two consultants and those of the district service workers. There was a climate of mutual suspicion.

In the same way, there tended to be a more 'stand-off' competitive relationship between our two consultants and those working in other departments in the Trust. Our two consultants were often overtly critical of their colleagues, perceiving them to be lax or less than fully competent in doing their jobs. This conflict arose particularly around their 'out-of-hours roster' in which consultants across the Trust were on call to deal with emergencies in evenings and weekends. William and Stewart frequently found in doing this that they were having to 'mop up' after their colleagues, doing their work for them, as they saw it, in crisis circumstances which could have been prevented had the other services been better organised. They saw many of their colleagues as lazy and cynical. This view meant that they were very opposed to our department having any links with others in which it might seem that we were "doing their work for them". They constructed an 'outsiders' and 'insiders' world view in relation to how the department's resources were used. William could be particularly confronting of his colleagues about this, which earned him some severe 'bruises'. It was less clear what Stewart's public stance was outside the department. One outcome of this within the department was a degree of confusion among staff as to how to relate to colleagues across departmental

boundaries - any such encounters tended to be kept to the private domain, and not for public discussion.

The major significance of these events was that the department now had only eighty percent of its budget secured through a contract with our local health authority. There was to be a 'lead-in' period during which we had to find ways of securing the other twenty percent. Failure to do so could lead to either of two options: merging with another department (adult psychiatric services); or staff redundancies. This created a very real 'edge' for change as the moves or the redundancies would most likely have to come from senior staff who would be seen as superfluous to a purely local and non-specialist district service. The two consultants often jokingly referred to being made redundant, but in such a way as to hint at a sub-text that they would engineer this deliberately if things did not go their way, a sub-text which was made overt by them on one occasion.

Jan as business manager was proposing that we engage the help of outside experts to develop a marketing strategy, to systematically explore the options and develop a business plan which would take the department through the next five to ten years. We aired the issues regularly in the core group and began looking at the way we could develop our services, talking about taking a stronger role in managing the sort of cases that 'fell through the net' of other services in the Trust as one of several possible directions. These later came to be recognised as 'complex cases' but at this stage there was little agreement about how we would 'manage' them. The two consultants were also very wary about any closer involvement with other departments implied by this direction, although William was the more enthusiastic of the two as it fitted more with his interests in eventually becoming a general manager.

We had by now lost social workers from the department due to reorganisation in the Department of Social Services. We were now only four in the core group - William, Jan, Stewart and myself. In anticipation of the forthcoming changes we had employed a full time Occupational Therapist and a full time Physiotherapist to provide the backbone of a more developed day care programme. I will tell more of the significance of this development later.

These changes created a dilemma as I saw it for the two consultants. The alternative options of merger or redundancy were anathema to them, but the marketing option also challenged their world view that they as consultants knew what was needed (the problem being that others would not always accept what they prescribed). There was an acceptance of the need to market, but there was conflict about how to go about it. The two consultants wanted a marketing expert to perform only a limited external role and to

leave the rest to us. On the other hand, Jan and I were committed to the department but were much more neutral about the other options, seeing interesting possibilities for joining with other departments if need be. Together we were in favour of outside expertise, and moreover we were interested in hiring people who would include us fully in the process so that we all learned the relevant skills for future needs. I will return to this in more depth in a subsequent chapter where I am confronted with power in relationships.

As individuals on their own, William and Stewart dealt with these issues differently. Stewart saw management as "flannel" and was frequently critical of management theory and practice. He saw it as thinly disguised code for implementing central government changes to the NHS with which he could not agree. There were times when I could wholly agree with him, but I also recognised that his core views about management were very different from mine. To the extent that I was able to discuss it with him on odd occasions, I came to believe that he constructed a world of management and management practice in which managers controlled others, by direct or indirect means. Alternately, they interfered with what others (who were more knowledgeable) wished to do. However if this was his starting position, I observed him over the years to cling less tenaciously to this, except when change was afoot with which he did not feel a part or with which he did not agree. He was a ready acceptor of change brought about by effective management if it met his needs. This was not an isolated position - I recognised it as a sub-text in the conversation of many consultants who had never been 'managed' before and were anxious and uncertain of the implications. However, like Stewart, many could be skilful entrepreneurs in gaining new resources. I will ground some of these observations in later experience recounted below.

On the other hand, William saw himself as a beginning manager and that this might be a strand on which he could develop his career. Outside the core group meetings he took a different attitude. Jan and William had developed a working relationship with each other in which there was increasing mutual trust. William was open to looking for alternative frameworks for managing and Jan had introduced him to Torbert's writings as a way of supporting this and as a means of providing a language in common to support their working relationship as Clinical Director and Business Manager. At that time there was a senior registrar working for William who was also doing an MBA and William shared some of Torbert's work with him. I would regularly join the three of them in informal discussions about his ideas. The two doctors were particularly interested in the developmental model of leadership and began using some of the stage names in relation to themselves and colleagues. They became aware that there were alternative

interpersonal strategies for inquiry than the ones they had developed through their training.

Finally, with the move to being part of a self-managed NHS Trust, all departments were under an obligation to develop a range of quality standards to meet the requirements of central government (for example, 'The Patient's Charter') and the various purchasers of our service. As Business Manager, Jan led this in the department and created a 'Quality Circle' of department members who were responsible for the day to day delivery of the various aspects of the service. In this setting we learned with each other about setting quality standards and auditing our work. The two consultants did not join this, exemplifying a pattern whereby they expected to lead, but from a distance rather than alongside others.

In the next chapter I introduce a concept from clinical audit to aid the development of a 'map' or set of 'good practice' guidelines for working with 'complex cases'. In the meantime, I will next describe the methodological possibilities I saw as being available to me for further inquiry.

Methodological Issues.

More 'Fine Print' from Collaborative Inquiry.

I will present here those aspects of Collaborative Inquiry which were formerly 'fine print' and which did not suggest themselves as being salient to me in my early foray into research. These features have become 'bold print' through the process of the inquiry so far, now speaking to and grounded in the actual experience of initiating an inquiry. The following quote from Torbert (1981) helped orient me more accurately towards the 'real' task facing me as a researcher in using Action Inquiry in my own setting, namely the development of conditions under which increasing collaboration can occur.

> "Because no acting system begins with the sort of embracing, interpenetrating attention advocated here, each actor requires others' best attention and sincere responses in order to learn whether his or her own purposes, theories, actions, and effects are mutually congruent. In other words, the aspiring action scientist requires others' friendly collaboration. A second reason why *collaborative* inquiry is necessary for effective action is that the 'topology' of social situations is determined by the qualities of each actor's intuitive, theoretical, sensual, and empirical knowledge and being. Consequently, each actor can gain increasingly valid knowledge of social situations only as other actors collaborate in inquiry, disclosing their being, testing their knowledge, discovering shared purposes, and producing preferred outcomes. As the actor-researcher increasingly appreciates

these motives for collaborative inquiry, s/he increasingly wishes to approach situations in everyday life as real-time, mutual learning experiments - as experiments-in-practice." (p147)

Torbert warns of adverse responses to the notion of collaborative inquiry and 'experiments-in-practice', from the indifferent to the hostile. While he advocates an inquiring approach to hostility (presuming the initiating researcher possesses sufficient virtuosity) he also sees attempts to either defend or impose collaborative inquiry as counter to its spirit. These possibilities show that the structure of an experiment-in-practice cannot be fully pre-defined and stable, but rather evolves over time.

• Experiments-in-Practice

The following are a set of characteristics of experiments-in-practice from Torbert's (1981) model of a Collaborative Inquiry which include but extend those noted in chapter four. They contain a richer appreciation, in the light of experience, of how they spoke to my inquiry so far and suggested ways of continuing for the future.

- The researcher's activities are included within the field of observation and measurement, along with the study of other subjects.
- The structure and variables are not fully pre-defined but rather may change through dialogue between the initiating actor-researcher and others as the inquiry proceeds.
- Interruptions are welcomed , symbolising that which is not present within the researcher's awareness at the moment of interruption, inviting a more encompassing awareness of what is at stake.
- Conflict between different paradigms of reality is anticipated and welcomed as an opportunity to make explicit and test as far as possible the assumptions held by participants. Such conflict will not only be intellectual but will also have immediate emotional and practical implications as well. Thus the aspiring action scientist is challenged from the outset to seek and offer information which is politically timely and aesthetically appropriate, as well as analytically valid.
- The ultimate criterion of whether a given action is aesthetically appropriate, politically timely and analytically valid is whether it yields increasingly valid data about issues significant to the effectiveness of any acting system. And whether it does so in such a way as to encourage a more encompassing, interpenetrating attention by these acting systems.

Experiments-in-practice have four conceptually separate 'media' of research (again, Torbert, 1981) as follows.

- An attention capable of interpenetrating, vivifying and apprehending simultaneously its own ongoing dynamics - the noticing and seeking to correct incongruities across the four territories of purpose, strategy, actions and effects. Such an attention spans the immediate and the long term.
- "Symbolic, ironic and diabolic thinking and feeling" (p.148) capable of apprehending the significant issues at stake, the values assumptions in actors behaviour, the degree of congruity or incongruity between purposes and effects, and the efficient paths for common effort.
- Action (movements, tones, words and silences) which is sufficiently "supple, attuned and crafty, to create scenes of questionable taste, to demonstrate the good taste of collaborative questioning and to listen silently to responses" (p149). Such action invites tests of its own and others' sincerity and effectiveness, and does not screen out strangeness and disconfirmation.
- The collection, analysis and feed-back of empirical data. The sort of empirical data sought is that which sheds light on the degrees of congruity and incongruity between and across the different territories of purposes, strategies, actions and effects.

The fundamental type of empirical instrument is a record of experience which comes as close as possible to an analogue of an embracing interpenetrating attention. This will be in the form of tape-recordings, field notes, personal diaries and so on. Such a record will allow participants and interested others to find post hoc clues about what else apart from pre-defined variables and explanations was occurring in any given situation. Torbert (1981) also maintains that such records can generate process data which can help determine whether the design of the experiment was open to challenge and reformation, and whether dialogue among participants was conducive to increasingly appropriate design decisions.

A final consideration which became relevant for me was Torbert's comments on the development of relationships between the initiating actor-researcher and other participants. He discerns three stages to this development.

- No matter how well prepared, the *primary question* for the initiating actor-researcher is whether s/he and the system/s engaged can come to share the aim of collaborative inquiry and share the model of interacting qualities of experience

(interpenetrating attention). It is only if this agreement about aims and models can be reached that the next stage can proceed. (Torbert uses the term "shared model of reality" (p.149) to refer to this agreement, but I prefer not to use this because of the epistemological assumption of a reality independent of the knower implicit in the term. He could be referring to a social consensus about what constitutes a co-evolved research 'reality', but as he is not clear on this I will avoid the term).

- The second stage represents a shift to examining incongruities across the different domains of experience. In this stage the participating systems are actively collecting and analysing experiential-empirical data, but they will focus more on the general direction of the findings than on the precise outcomes.
- The third stage is possible only if the first two are attained. The focus then becomes obtaining precise high quality results in terms of aesthetic appropriateness, political timeliness and analytic validity.

In short, Torbert (1981) says "valid social knowledge becomes possible only as fundamental changes occur in people's commitment to personal learning and in their ways of organising socially."(p151)

Elsewhere, Torbert (1981b) talks in terms of developing a Community of Inquiry, a lifetime circle of friends dedicated to helping clarify, and if necessary challenge, each other's purposes and actions. While teachers and leaders can certainly initiate such a process among themselves, he warns that they must also maintain a paradoxical balance across dilemmas about how they use their power ethically to encourage an inquiring interpersonal strategy in others. He also notes that participants in collaborative inquiry may experience an initial sense of loss of control as they attempt to develop competencies in using inquiring interpersonal strategies which require self disclosure about one's experience, supportiveness and empathy towards others, and confrontation of incongruities across domains of experience. He speculates that this may be due to the disorienting effects of being participants in encounters where there is a move away from implicit acceptances towards explicit questioning of rules and incongruities.

It is in his Power of Balance (Torbert, 1991) that he links collaborative inquiry with his theory of power and his model of leadership development to begin defining how to go about creating a community of inquiry in one's life and in one's work organisation. However, at this stage of my inquiry, the above characteristics of collaborative inquiry seemed to speak more to my purposes and my actions than did the theories of power and qualities of leadership.

Torbert describes the use of experiments-in-practice, at the heart of Collaborative Inquiry, as an experiential process occurring in a more or less distorted and incomplete fashion at any give moment. It was this quality I understood now in a more grounded sense by my newly made sense of my inquiry so far. It suggests a more emergent and discontinuous process (which matched my own experience to date) by which an inquiring interpersonal strategy develops individually and organisationally. It also describes in more detail some guidelines for how the individual needs to think and act in order to co-create with others the sort of wider relationships and an organisational context which will contain and support increasing mutuality of commitment, authenticity and collaboration.

Contributions from a 'Hermeneutic Dialectic Process'.

Guba and Lincoln (1989) detail an approach to programme evaluation based on their constructivist philosophy (described earlier in Chapter Four) which seeks to take evaluation away from a technical 'fact-seeking' exercise to include the myriad social, political, cultural and contextual factors involved in the delivery of any service - be it an educational or health care programme. They call such an approach 'Fourth Generation Evaluation' and take the position that any findings of an evaluation represent a set of constructions, including those of the evaluator, with associated values which are formed in the multiple contexts in which the persons involved live. Furthermore, they recognise that any evaluation can be shaped to either enfranchise or disenfranchise the multiple 'stakeholders' associated with a programme. Therefore they advocate a form of evaluation which seeks to honour the constructions of all the stakeholders and in so doing create the conditions for educating, empowering and preserving the dignity of all involved.

Fourth Generation Evaluation draws both draws upon and extends their earlier (Lincoln and Guba, 1985) constructivist paradigm for social science informing their model of Naturalistic Inquiry. The process by which the constructions of all the stakeholders are elicited and negotiated in a fourth generation evaluation is called by Guba and Lincoln (1989) the Hermeneutic Dialectic Process, and this is linked with their Naturalistic Inquiry to form the overall methodology for evaluation. It is the Hermeneutic Dialectic Process that I will describe here and consider for my own use.

"The major task of the constructivist investigator is to tease out the constructions that various actors in a setting hold and, so far as possible, to bring them into conjunction - a joining- with one another and with whatever other information can be brought to bear on the issues involved" (Guba and Lincoln, 1989, p. 142). This suggests implicit links between aspects of Collaborative Inquiry and aspects of Naturalistic Inquiry. The former places much emphasis on developing a self reflexive interpenetrating attention in acting

systems, the latter on elucidating the constructions of all the stakeholders in the field of inquiry. Carrying a constructivist set of lens while exploring collaborative inquiry and experiments-in-practice did not seem mutually exclusive. I will present the key elements of Guba and Lincoln's Hermeneutic Dialectic Process then consider how I saw this as contributing to my inquiry.

The authors take the view that constructions held by persons consist of certain available information configured into some integrated, systematic 'sense-making' formulation whose character depends on the level of information and sophistication (in the sense of ability to appreciate/understand/apply the information) of the constructor.

Constructions come about through the interaction of a constructor with information, contexts, settings, situations, and other constructors - not all of whom agree. The process used is rooted in the previous experience, belief systems, values, fears, prejudices, hopes, disappointments and achievements of the constructor/s. Within this heuristic there are as many constructions as there are constructors, and they are both self-sustaining and self-renewing. Constructions are changed whenever new information and/or an increase in sophistication to deal with information becomes possible.

• Conditions for change.

Guba and Lincoln (1989) propose four possible conditions under which changes in constructions can happen.

- Condition 1. *Stability.* New information is introduced that is consistent with the existing construction and does not require any change in the constructor's sophistication to deal with it.
- Condition 2. *Information Disjunction.* New information is introduced that is inconsistent with existing construction, but does not require an increase in level of sophistication. A usual first response is to regard the new information as error, but repeated presentation of the same information leads to a change in the prevailing construction to accommodate the new information. Such change is slower and more reluctantly engaged upon than in condition one.
- Condition 3. *Sophistication Disjunction.* New information is encountered which is consistent with the existing construction but which requires an altered level of sophistication so that the constructor can appreciate/understand/apply it. An example would be a scientist who collects more data which leads to a more refined data set, but who realises that existing theory no longer adequately accounts for the data. She then sets about developing a more sophisticated theory. Such a change typically does not require a paradigm shift leading to wrenching shifts in

interpretations, but may prove challenging and puzzling, leading to a re-examination of the constructions held.

- Condition 4. *Information and Sophistication Disjunction.* The extreme form of this condition is a paradigm shift which places much stress on the holders, leading to a period of bewilderment and confusion. Constructors are immobilised so long as they are unable to gain the perspective needed to facilitate the paradigm shift. Change is very slow and painful and may be beyond some individuals.

The ease with which a construction may be changed thus depends on which of these four conditions is encountered. If the holders of a given construction are to change, it is essential in Guba and Lincoln's (1989) view that they be exposed to new information and/or given the opportunity to grow to whatever level of sophistication may be needed to appreciate or understand or use that information. "What is needed to effect change is an open negotiation during which all available constructions, *including that....which the inquirer/evaluator brings to the inquiry*, must be open to challenge - and to the possibility of being discarded as not useful, unsophisticated, or ill informed. All constructions must be afforded an opportunity for input and must be taken seriously, that is the input must be honoured." (p148).

Guba and Lincoln propose a process they call Hermeneutic Dialectic which they see as fulfilling the above conditions. It is hermeneutic because it is interpretive in character, and it is dialectic because it seeks to compare and contrast divergent views with a view to achieving a higher-level synthesis of them all, in a Hegelian sense. The major purpose is to form a connection between different constructions that allows for an exploration by all parties concerned. The aim is for consensus, but if this is not possible, then at the very least the process exposes and clarifies the multiple views and allows the building of an agenda for negotiation. The authors see all parties to such a process as simultaneously educated and empowered. They propose conditions for such a successful process.

• Conditions for a successful process.

- A commitment from all parties to work from a position of integrity. That is, there must be no deliberate attempts to mislead. The authors believe their process minimises this likelihood.

- Minimal competence on the part of all parties to communicate. Thus special consideration needs to be given to children or learning disabled adults or the mentally ill.

- A willingness on the part of all parties to share power.

- A willingness on the part of all parties to change if they find the negotiations persuasive.
- A willingness on the part of all parties to reconsider their value positions as appropriate.
- A willingness on the part of all parties to make the commitments of time and energy that is required for the process.

At this point, I wondered about how achievable such conditions were in my work setting. I reflected that these conditions mirrored my own sense of authenticity as a person and that I also chose to see that others did their best in any given circumstances, taking into account their own values, view of the world, history and current circumstances. Nonetheless, I recognised this as a set of ideals which I held on to in the knowledge that I would be disappointed from time to time with both myself and others. However, as conditions for a successful hermeneutic process, they offered considerable challenge to the evaluator/inquirer, the participants and the process. Guba and Lincoln draw these from their own experience and believe them to be necessary, but are not yet sure if they are sufficient to achieve their aims of evaluation being an educational and empowering process.

• Carrying out the process.

A cyclical process is recommended whereby the investigator visits each respondent or stakeholder in a sequential fashion, eliciting their constructions on the issue at stake, then offering the constructions of previous respondents for comment.

The first respondent (R1) is either chosen or nominated for a salient reason. R1 is engaged in an open ended interview to determine initial constructions of whatever is being investigated. She is asked to describe the focus as she sees it and comment on it in personal terms. R1 is then asked to nominate a second respondent (R2) who is as much different in views from her own as she is able to identify. The central themes, concepts, ideas, values, concerns, and issues proposed by R1 are then analysed by the investigator into an initial formulation of R1's construction (C1), using a comparative method the author's describe in their model of Naturalistic Inquiry (Lincoln and Guba, 1985).

Next, R2 is interviewed and allowed as much freedom as R1. However, when R2 has volunteered as much as appears probable, the themes from R1 are introduced and R2 is asked to comment. As a result, the interview with R2 gains not only their views but also their critique of R1's. The inquirer then seeks a nomination for R3 and completes

an analysis C2, a more informed and sophisticated construction based on two sources, R1 and R2.

So begins a process of building an increasingly more informed and sophisticated construction of the issue at stake. The process is repeated with new respondents being added until the information received becomes redundant or falls into two or more constructions that are at odds in some way (typically because the values which undergird the constructions are in conflict).

As the process continues, the degree of detail sought in the interview and the degree of structure can change. As salient issues begin to emerge, the investigator can seek a more detailed and articulated view of them, and can change the structure of the interview from being open ended to asking more focused and pointed questions. When the circle of respondents has been completed, a second pass can be made and so giving the earlier respondents an opportunity to comment on a more refined and elaborated construction which hitherto they have not had. Alternatively, the circle may be 'spiralled', making a second pass with a different set of respondents who are similar to the first.

Finally, the investigator may introduce perspectives for comment from other sources. These may be from another set of stakeholders in another part of the organisation, from observations made during the process, from the literature and so on. The investigator's own constructions may be introduced for critique. The authors suggest a neutral presentation of constructions from other sources, such as 'some people think....' to avoid undue influence arising from perceived status or power of the sources.

Circles can consist of persons who are widely different from one another, but the authors warn that the minimal conditions for success are less likely to be met because the individuals, for instance, may have widely different power within the setting.

The criteria for the quality of the knowledge gained are those I outlined in chapter five.

My reflections on the potential usefulness of the methodologies.

I saw the context and the purpose for which Guba and Lincoln propose the above process as being different from mine. They see this process as one of primarily evaluation, where the investigator comes into the setting explicitly for a bounded and negotiated purpose, even though that may change as the evaluation proceeds. The framing of their involvement as 'evaluation' and the process by which they go about it may increase the likelihood of their conditions for success being met.

By contrast, I was considering using this as an insider, without explicit invitation to evaluate or investigate. I was a participant and a stakeholder and as much as anybody else needed to be on the same level with respect to the inquiry in making my own values and constructions available to the process. Furthermore, the use of this process would necessarily involve individuals with differing types and degrees of power, and different degrees of willingness to make commitments to give time and energy, to change if they found negotiations persuasive, to reconsider their value positions if appropriate, and to share power. I saw a failure in the method to draw distinctions between what were necessary initial conditions for success at the outset, and what conditions might be approximated more closely through the process of evaluation.

Nonetheless, I saw within the Hermeneutic Dialectic Process a core notion of how I could move around different individuals or groups in our department and both seek and honour their constructions of events while at the same time enrich and elaborate both my own and others around dealing with 'complex cases'. The challenge at the time seemed to be one of creating the conditions where such collaboration as outlined by Guba and Lincoln (1989) could be achieved. Torbert's (1981) Collaborative Inquiry offered an interpersonal strategy which could help towards this. The two modes of inquiry seemed as though they could interact and inform each other in a complementary manner. In the following chapter I explore the utility of these two in a 'mini inquiry' into the possibilities for collaboration around the point of referral for a 'complex case'.

11. TOWARDS 'GOOD PRACTICE' GUIDELINES FOR 'COMPLEX CASES'.

Introduction

My earlier inquiries into practice with 'complex cases' had revealed a number of patterns which occurred around their management. It was now my objective to become involved in 'complex cases' from the point of first contact because one of the patterns I had discerned was the limited and unsystematic degree of negotiation with the relevant groups and individuals prior to and around the referral to the service. My purpose in involving myself at this point was to both understand more fully what the issues were, and to have a stronger influence in how the 'cases' were managed. I believed that if a much greater degree of collaboration could be introduced from the outset then later problems and pitfalls could be minimised, and continued collaboration would be more possible.

I hoped that this greater understanding would help me in facilitating the more explicit and systematic practice with 'complex cases' across the department that I was seeking. I was at this stage still seeing a focus on complex cases as holding the research questions I was pursuing - understanding how I worked as a psychologist, exploring possibilities for teamwork, and looking to support the immediate 'organisation' towards being more of a community of inquiry which was more self-reflexive and 'alive' to itself. This chapter is about making preparations for a more explicit and systematic inquiry into 'complex cases'.

In addition to exploring ideas from Collaborative Inquiry and the Hermeneutic Dialectic Process, I borrowed a concept called the 'Patient Journey' from clinical audit work in the health sector. I will describe this briefly below. This concept appealed as offering a conceptual map which all staff could share in developing a commonly agreed set of 'good practice' guidelines which would serve to inform quality practice from the moment of first contact through to discharge. I saw this as providing a potential focus for developing the first stage for a Collaborative Inquiry as described in the last chapter, where the initiating actor/researcher and other participants come to agree an aim for inquiry and share the model of an interpenetrating attention.

My involvement in assessing and care-planning with a client called Rosemary provided an opportunity for a 'mini inquiry' in which I could test out these ideas. It is this I will recount in order to describe the issues as I saw them and to describe the process of inquiry which suggested a pattern for a later more prolonged inquiry. Within this mini-inquiry I saw patterns of relationship and constructions of meaning that I was to recognise as recurring over time around other issues among health professionals. I held an assumption from systems theory (e.g. Hoffman, 1981) that patterns of relationship around one problem or issue can be seen as an analogue or isomorph of patterns of relationship which will recur at other times and in other places within the same group. This assumption is more likely to hold if the same people are involved, but can apply if one or more people occupy the same role at different times.

I will begin by describing the 'Patient Journey' concept, then recount Rosemary's beginning to her 'patient journey' through our service. I then reflect on what lessons are learned from this for a more prolonged and wider inquiry to establish 'good practice' guidelines.

The Patient Journey.

This is a concept widely used in managing clinical work in health services and refers to the sequence of events in providing an episode of treatment and/or care to a patient from the point of entry to a service through to discharge. It is one that I had found as offering considerable utility in conceptualising how to deliver services more systematically, and how to structure what can become confusing encounters when thinking about allocation and management of resources. I had developed my own set of understandings over the years, and I will present this here as a 'framework' for thinking about how to structure the delivery of a service with 'complex cases'. The framework is not intended to be prescriptive, programmatical or normative. Rather it is something which I had 'co-evolved' over the years through dialogue with others and with my own experience and which I held loosely in order to amend it in the light of new experience and new dialogue. Its utility for me lay in providing a language for talking with other health workers at times when we needed to think at the level of 'organisation of services' as opposed to delivery of service with an individual patient. We could then arrive at a consensus agreement about how 'punctuate' our work into chunks which may require different staff with different skills at different stages - for example an initial brief assessment of immediate need could be followed by a more comprehensive assessment of longer term needs, which may be followed by a detoxification, and so on.

What I am briefly describing here is my own set of understandings which I thought I could bring to the task of developing a more explicit and systematic understanding with others about how we worked with 'complex cases' as a group. The patient journey as I conceptualised it requires the identification of the significant steps needed to successfully take a person through an episode of health care. 'Good Practice' guidelines can then be derived for each step by the workers involved which inform how they can implement interventions or processes to achieve optimum quality care. These guidelines are informed by research and the research literature (giving information on 'what works best' for a given problem); by 'bench marking' with other agencies providing similar services (how they have implemented 'what works best' and with what outcomes); and by inquiry within local settings and conditions (what 'works best' for us).

Having established good practice guidelines, standards can be set for each step of the Patient Journey which represent ideal outcomes in a tangible and measurable form. This can enable auditing when problems occur in order to identify factors which require change. It can also inform the concept of 'Risk Management' in health care. If good practice guidelines or standards are departed from in any circumstances, the clinicians involved need to be able to rationalise these departures in terms of either resource limitations, patient characteristics or

local conditions. Provided departures are accounted for in this way and appropriate action taken, then risk is deemed to be adequately managed. In this way, the probability of quality care being provided is seen to be reliably improved.

This process is much easier in medical health care which is technological in focus, more easily described in digital and quantitative terms, and neatly bounded in time and place - such as many surgical procedures. However my experience in mental health care, with its interpersonal process rather than technological focus, is that good practice guidelines (how to implement) are much less likely to be informed directly from the research literature (what works with any given problem). Rather, they are more likely to come from quality and audit literature where other workers describe their work (a form of bench marking), from literature with a case study approach, and from local inquiries into 'what works best in this setting'.

I will illustrate with an example from my own prior experience shortly after starting in the department. I employed a research assistant to inquire into clients' experiences in coming from the referring agency to the point of first assessment at a routine outpatient assessment clinic. She and I developed our own tentative understanding of the steps in this part of the patient journey then elaborated on these through inquiry with clients and the clinicians seeing them. From this inquiry into the constructions held by the different participants, we were able to identify changes required to meet both clients' and staff's expectations and needs, including training of staff in particular skills. This previous experience had shown me the utility of the framework for routine initial encounters with more straightforward presenting problems which could be addressed by an individual worker. I saw it as having potential applicability for more complex situations, but also saw that I would need to hold it lightly and offer it up for dialogue and change according to how my inquiries progressed. I knew from past experience that different workers held different constructions about what constituted the 'patient journey'. I was interested in seeing if a more explicitly negotiated set of constructions could be developed from our local practice which included as many 'stakeholders' as possible.

A 'mini-inquiry' into the first steps of the 'Patient Journey'.

I will firstly give some background to Rosemary's story to 'set the scene' and expand the contexts available for making sense of the encounters. I am seeking not to repeat the earlier, more detailed, story form I used as representation of my participation in 'complex cases', but will dwell a little in detail at this point in presenting Rosemary's story. This will enable me to take meaning about the service dilemmas I saw around her referral.

Rosemary's story.

Rosemary was a young woman in her mid twenties who had a professional training, but who had not worked for more than six months at any one time. She had been unemployed since marrying one year ago and was not coping with the demands of a committed and intimate relationship as she perceived them to be. As a result she was in frequent conflict with her husband and lived between their apartment and her parents' home. However, when at home

with her parents, conflict would erupt between her and her mother, with the result that Rosemary would become violent towards her mother and then damage property in the house. She would then become suicidal and disappear for one to two days at a time, usually being picked up by the police standing near a bridge or upon a high building.

Admission to her local psychiatric hospital would follow, with her staying for several weeks before discharging herself back home. In hospital, she would become self-mutilating on some occasions. Once back home, the pattern would start again. Most of these incidents happened while Rosemary was drinking heavily.

At the age of sixteen, Rosemary developed the eating disorder called Bulimia Nervosa. Believing she appeared fat and overweight, she would diet severely to keep her body image within limits she perceived as acceptable. Dieting would be punctuated by regular binges on excessive amounts of food, usually triggered by hunger or some form of emotional distress. Feeling intensely guilty and fearful of having put on weight, Rosemary would then empty her stomach by self-induced vomiting. This would then be followed by further dieting and a continuation of the viscous circle.

All of Rosemary's family of origin were diabetic and the management of this condition through dietary control had a strong influence in the organisation of family life. Rosemary often wondered in retrospect whether her feeling excluded from the closeness and the drama the other's experienced because of this was causally connected with her eating disorder.

Her parents had tried unsuccessfully over the past ten years to get her to engage in various forms of treatment. Rosemary had initially complied but was ambivalent about making change. However, more recently, her ambivalence had begun to swing towards the felt need to change as she increasingly felt out of control and correspondingly more desperate. She had developed a dependence on alcohol. As she told me, it was more acceptable to tell people "I get drunk" than " I throw up most days of the week!" As Rosemary became more desperate she engaged in forms of self-mutilation in an attempt to break the vicious circle she perceived herself to be caught within..

Her parents were also becoming increasingly desperate and were in dispute with the local health authority. Believing that the only effective remedy now was long term in-patient treatment in one of the London specialist hospitals for eating disorders, they had been unsuccessful in obtaining the health authorities permission to fund this. Not accepting this, Rosemary's parents had obtained the support of their local MP and eventually persuaded the health authority to concur.

Alongside the referral to our service, Rosemary's psychiatrist had also made referrals simultaneously to several units specialising in the treatment of eating disorders, and also to a colleague in our own Trust who had a special interest in eating disorders and was internationally renowned. Because of the long waiting lists, the referral to us was for interim

help with her drinking problem. The hope expressed in the referral letter was that we could somehow minimise the crises which occurred around her drinking. Rosemary had not engaged well with her local mental health services and it was felt by the referrers that this was in part due to her alcohol misuse, and partly due to the nature of her 'disorder'. She was seen as having a Multi-impulse Personality Disorder. This was a diagnostic label derived over the last decade to describe the above cluster of phenomena, seen as stemming from a personality constellation characterised by impulsivity and difficulty in tolerating emotional arousal. The dysfunction is seen as being located within the individual, and ignores the contexts in which it arises. There is no particular treatment approach suggested by the application of the diagnosis, but it suggests that the individual will not be able to respond readily to treatments of eating disorders which have been shown to be relatively successful with others of a more 'robust' personality.

As an aside, the language of diagnoses is not part of my day to day narrative about working as a psychologist. I can speak the language and find it useful on occasions to be able to communicate with those who use it to reflect their dominant framings of mental health. Diagnostic labels have utility for me only at a broadly descriptive level to suggest what phenomena are likely to be experienced by the individual. They operate at a different logical level from the process of therapy and change and do not reliably predict what course of action is required in order to intervene helpfully.

A first inquiry with Rosemary.

I became involved with Rosemary at the point of initial assessment in an outpatient assessment clinic run by a small group of nurses, doctors and myself. We allocated cases between ourselves according to interest and at the same time matching referred problems with relevant skills. Occasionally we conducted assessment sessions in pairs. On this occasion I was joined by Luke, an experienced Clinical Nurse Specialist.

There was no clarity in the referral letter about whether the referrer was transferring total responsibility for the case to us, or only asking us to support treatment while the referrer retained responsibility. What was further unclear was who else was going to be involved, given the multiple simultaneous referrals. Luke and I were a little unsettled by this 'recipe for confusion' but decided to see Rosemary first and to gain her views before seeking further clarification.

Rosemary attended with her father and was seen jointly with him and also on her own. We heard of the problems they faced and their views of the current situation. Father did not see this referral as meeting his view of what was needed and was polite but firm in this view. Rosemary was keen to get help, but on terms which were different from those of the referring psychiatrist and her parents. She had her own views about what the problems were and how she wanted to work on them. There was implicit and explicit conflict between the two, but also evident closeness. However, both she and her father shared the opinion that in-patient

treatment was the only acceptable option - they were worn out by crises and felt nothing had worked to date.

At this point I considered a number of dilemmas I saw surrounding this 'case'. I believed I needed to find a way of working with the family in which I could join therapeutically, but at the same time avoid being seen to support one viewpoint about the nature of the problems at the expense of others. I needed to retain a degree of neutrality about this until such time as the therapeutic system-to-be-worked-within had been defined and a consensus reached about the focus of the work to be done. If I could not retain this type of neutrality, then I risked becoming part of the pattern of escalation I had discerned from the family and the referring letter. Furthermore, our department could not provide the degree of intensive nursing support required when individuals were suicidal. Therefore, the referring psychiatrist would have to remain in the picture in the likelihood that the above crisis pattern occurred again and we were unable to prevent it. I did not know how my psychiatrist colleagues in the department would view this as there was a tradition of consultants either managing care or giving opinions, but not a tradition of sharing care through negotiation.

I was also a little anxious about the degree to which we could meet the needs of Rosemary and her family as our department had not yet had much collective experience in managing this type of problem. Yet in developing our departmental philosophy we had agreed to take a broad view of what constituted addictive behaviour. In the core group we had decided that we would work with any individual who engaged in repeated cycles of self-harming behaviour, particularly if drug or alcohol misuse was involved. Rosemary fitted this description so she presented us with not only a challenge but an opportunity to develop effective ways of working with her.

A further factor to take into account was that I knew my two psychiatrist colleagues, William and Stewart, did not believe hospitalisation was required in order to treat eating disorders. Once in psychiatric hospitals, the boundaries about who was responsible for the individual's intake of food, and the health consequences of that, created double binds around issues of 'control' for both patient and staff. There was an increasing view among mental health professionals that hospitalisation was only warranted when the patient was physiologically in emergency, and then admission to a general medical service was needed. I would have to negotiate through this potential polarity as well.

And finally, I felt as though the different agencies and individuals who had become involved formed a potentially critical audience who would watch with interest what we did. Would I meet expectations? Would we as a department be seen to be doing a good enough job?

Against all that, was Rosemary's demeanour in the session. She was very tense and wary, yet also had clear ideas about what she was looking for in terms of help. She struck me as being very present in the session and as seeking to find a safe place in which to explore change at her own pace. In seeing her alone and asking her views about 'what needed to happen for

things to change', she told us with some feeling "I am sick and tired of focusing on all the negative aspects of myself. I would like to develop the good parts, the talents I know I have." This could be construed as signalling her continued ambivalence, avoiding directly facing the 'giving up' of her alcohol and eating problems. But it could also be construed as 'taking charge' of her own experience and as such, needed to be supported as a more viable form of agency in the face of chaos. Furthermore, I thought she was offering us a frame for working with her which neatly bypassed many of the dilemmas about focusing on alcohol versus eating disorder, and about potential polarities around 'who was in control' which were strong sub-texts in the 'stories so far'.

During a break in our session Luke and I discussed these issues. Luke thought she was "shopping around" and not serious about engaging with us. He thought we should let her visit all the other agencies before deciding, despite the sense of impending further crises. That part of me which was anxious allowed Luke's view to have weight. Perhaps he was right, and that approach would save a good deal of work negotiating through the maze of different views and agendas. But I could not let go of my other impressions of Rosemary struggling for survival and wishing to exercise agency in the type of help she received. I also knew that if we went with Luke's suggestion, there would inevitably be further crises as there would be no relationship or potential relationship which would 'hold' the family in some frame of hope. To some extent, she could be seen as "shopping around" with the help of her father - but why not? Surely clients should exercise choice! It was our job to create the conditions in which she might choose to work with us.

With both frames jostling for ascendancy, I suggested we tell the two that we would like to help, but with two provisos. Firstly, we would not wish to treat her alcohol problem separately from her eating disorder and related difficulties as they were part of an indivisible whole. This would address both Rosemary and her father's concerns, but this framing also needed to be tested for acceptability with others in the professional network. Secondly, in order to know if we could help by providing inpatient care we would need to discuss the case further with our own colleagues. Luke deferred and we presented this to Rosemary and her Father who agreed with this proposal and to a further meeting.

An inquiry with the professional network.

My task was to get a clearer map of the different viewpoints held by those professionals who were going to be significant in developing an initial care plan. From there I could begin negotiating a common frame in which we could begin working with Rosemary and her family, one which honoured the dominant constructions of all involved about the nature of the presenting problems and the help needed, while at the same time providing possibilities for further negotiation and change.

I first needed to gain the viewpoint of medical and nursing colleagues to see what the possibilities were before contacting the referring team members. I decided to gain William's

viewpoint first as the consultant who would take medical responsibility for Rosemary as an in-patient. I knew ahead of time that he was interested in working with these sort of problems. I also knew from previous conversations that he liked people to come to him with solutions as well as problems, and equally I knew he could abruptly dismiss solutions which fell outside his view of what was needed. The dilemma for him was likely to be how we could rationalise in-patient care when the tradition he had tried to establish as Clinical Director had been towards only brief admissions. As I have mentioned, I predicted he would be particularly dubious about admitting someone with an eating disorder.

In conversation with William these indeed proved to be the issues he was concerned about. After discussion I suggested that we could offer to admit Rosemary for a detoxification from alcohol, then have her stay on for a three week period where, free of alcohol, she together with us could gain a clearer picture of her needs. William agreed with this.

This intervention would offer an initial way through the dilemmas of the referrer, ourselves and Rosemary and her family who were not yet committed to a particular service. It might also create the conditions for further change as it seemed that no-one had worked with Rosemary while she was alcohol free for a sustained length of time. I also saw it as being able to incorporate Rosemary's framing of being able to focus on her strengths and talents, and it would enable her to exercise an informed choice about which agency she committed herself to working with. But I did not include this latter observation at this stage in my conversation with William.

We also discussed what the implications would be if during an admission Rosemary became either suicidal or engaged in self-harm to the extent that she needed close supervision. William decided that the referring psychiatrist would need to take Rosemary back into her local psychiatric ward, although he expressed unease at the difficulties he foresaw in getting a clear agreement with the referring psychiatrist about consultant responsibility. He was keen that we be able to provide for her needs within the department.

The next person I needed to see was Ann, the Nurse Manager of the ward, and talk through the implications for the nursing team of working with Rosemary in this context. Ann was worried about Rosemary's self harm and her eating disorder and the degree to which the nursing team could provide support to her in managing these. Conventional inpatient treatment for eating disorders required very tight contractual agreements about how much the individual needed to eat in return for earning privileges. There was much debate about the long-term effectiveness of this approach, but what remained was a generally held framing that working with clients who had eating disorders somehow involved struggles over issues of control, leaving many wary about the degree of conflict thus engendered and how this could be managed while at the same time keeping a rapport with the individual.

Our ward had a lower patient to nurse ratio than would be needed if such close supervision and support were required. I introduced the agreement with William that the extended

admission should be for assessment only and that perhaps we should not attempt to urge Rosemary to make changes, merely to help us understand more clearly what the problems were. Under these circumstances the choice remained with her about how she ate. We could certainly support any changes if she so wished, but only if she felt ready. Ann agreed that under those circumstances the nurses could certainly work with her as an inpatient. I made it clear that I would work closely with Rosemary and the nurses in developing this care plan. We agreed that the services of the occupational therapist and the physiotherapist would be needed to provide a range of activities during the day time which would meet with Rosemary's goals, to allow for an assessment of her needs while alcohol free, and to support her in staying alcohol free during her stay.

I met with these two next. They were new in the department and were unsure about their roles and how they could be seen to be effective with this client group. However they were very experienced in their own fields and contributed ideas about what they could offer. I offered conjectures about what I thought Rosemary's needs would be when she stopped drinking and we mapped the possibilities for providing structure and support. Both agreed to meet with myself and Rosemary after admission to negotiate a day time programme with her.

With a map of how we as a department could proceed I was now able to talk with the referrer and other team members from Rosemary's local service to gain a clearer view of how they were seeing the situation. The overriding view from them was that Rosemary had failed to engage in any treatment they had attempted to provide in the past and had only attended sporadically. The team psychologist had offered individual therapy but had only seen her on two occasions. In the group programmes they had offered, Rosemary was seen as actively involved in supporting others but not involved in talking about her own problems. The referring psychiatrist preferred that Rosemary be treated locally, but in the circumstances felt she had no option but to refer to the London services. She was sceptical that Rosemary would engage in any such treatment, because of her 'underlying personality disorder'. She was feeling exasperated and hopeless about the continuing cycle of crises. In particular, she was both worried about and feeling pressured by Rosemary's husband and parents as they were becoming increasingly stressed and looking to her for solutions which she felt she could not provide. Although she had considered detaining Rosemary for her own protection under the Mental Health Act, there were insufficient grounds.

Despite this, I could not get any sense that the consultant psychiatrist was wanting to 'let go' the case and ask another service to 'case manage'. This was a mixed message of despair, of looking to others for solutions, but also of not wanting to 'let go control'. She was happy to accept our offer, but behaved as if she was still case manager and would continue to pursue the referrals to other agencies and make decisions about longer term plans. We agreed that I would keep her informed about progress. I decided that as I could not get clarity about 'who was the responsible consultant' then I could at least put boundaries around my work. I could

claim the role of 'key worker' in our department and if the consultant roles became an issue then it was up to William and the referrer to clarify this. In the meantime I was wanting to keep my relationship with the referrer as collaborative as possible, and could easily work within a frame of 'case support' instead of 'case management' where the relationship between the two services was concerned.

At this point I recalled a recent conversation with a male consultant who viewed a referral to another inpatient service as a sign of personal failure. He felt he could provide any treatments a patient needed, and if referral was required it was only because the nurses on his ward were not able to manage. These were the only grounds on which he would countenance a referral. I wondered if Rosemary's referring consultant was operating under the same set of beliefs. I was later to learn that she did, but would also 'flip' to the other pole by asking for other wards to take her patients then not accept them back. In this way she engendered much covert criticism from her male consultant colleagues. It seemed they were unable to negotiate with each other about supporting each other's casework.

Reflections on 'mini-inquiry'.

• Personal learning.

At this point I considered what I had learned and what had been achieved. I had inquired of individuals and representatives of groups who had been immediately involved, and who either needed to remain involved because of statutory roles or because they could contribute to finding solutions. There were conflicting constructions (both implicit and explicit) among the professionals about who would remain overall 'case manager'. There were conflicting constructions (both implicit and explicit) amongst all involved as to the nature of the problem/s and how they should be addressed. But there was agreement among professionals on the offer of admission, and on the terms of the admission.

I could also see potential for agreement between the relevant department members and Rosemary and her family on the immediate focus for the work to be done - a detox and assessment of need for further help. I knew that Rosemary and family wanted in-patient care, but I needed to negotiate the terms of this with her within the frames we had discussed amongst ourselves within the department.

Following such a negotiation, Rosemary accepted the terms of the admission and stayed for four weeks as planned. She pursued her goals of focusing on the 'positives' but paradoxically in so doing also allowed us to see more of the problems she was facing and began to trust us to work with her on them. I urged her to accept the assessment appointments with the other specialist services when they were offered so that she could make the best possible choice for herself. This she did. As it turned out this was the beginning of a two year engagement with us which I will return to from time to time to illustrate and inform further inquiry in subsequent chapters.

From these encounters I saw a tension between the 'implicit' and the 'explicit'. The challenge was to know how far to go in making the implicit explicit. Too much surfacing of the implicit, and too soon, risked heightened difference and hence probable conflict and/or loss of face in already difficult and potentially dangerous conditions. Too little risked there being insufficient richness of data from which to construct similarity and agreement necessary for continued collaboration. The metaphor of 'balance' occurred to me in which I needed to pay attention to whether either was happening at the expense of the other.

• The Patient Journey.

In relation to the patient journey, my reflections at the time were that several issues had been suggested by this mini-inquiry as needing further consideration. There seemed to be a number of stages which may constitute important first steps in the patient journey of 'complex cases', around which guidelines for 'good practice' would need to be developed. My tentative findings so far about these were:

- The needs of both the referring person/team and the client/family must be inquired into and clarified as far as is possible and as is necessary in order to know whether or not we can 'do business together'.
- Whether the referrer or ourselves becomes 'case manager' was an issue needing clarification. This may be difficult to gain complete clarity on, especially if the referral is initially from one consultant to another. Perhaps a way forward is to think of ourselves as either 'case managing' (taking whole responsibility) or 'case supporting' (contracting to do a bounded area of work while referrer retains case management).
- Considerable negotiation is needed across the individuals involved. It seems that one person needs to retain responsibility for this in order to successfully 'orchestrate' the process. This person needs to have sufficient authority and expertise to obtain the consent of the individuals to participate. Part of the expertise lies in knowing what resources are available (and what the pattern of that availability is) within the service, and in being able to negotiate an initial broad 'match' between needs and resources.
- This same individual needs to be the person who also coordinates an initial 'care plan' around a broad focus with which all involved agree, and all of whom contribute to its drafting.

There was a strong degree of resonance between these tentative findings and what I had observed in earlier work with 'complex cases' after the point of admission. My tentative map about the process of working with 'complex cases' had been elaborated and it was bounded now by experiences from the point of entry to the point of discharge. I needed to ground these in further inquiry and to see how much these tentative findings would fit with or be elaborated by others' constructions about the process of care and treatment. There was a further boundary to be explored and that was the one at discharge. If in fact we were to offer 'case

support' as an intervention, then the process of 'handing back' to the 'case manager' with a viable care plan, with which all involved could continue working, would also require careful negotiation and planning which involved all parties. There was much more to be done yet.

• The inquiry process.

This process had been driven by my own sense of what 'good practice' was, being informed by some of the experiences and practice frameworks I have described in this thesis so far. At the time, my reflections about the relationship between practice frameworks and the strategies of Collaborative Inquiry and the Hermeneutic Dialectic process were as follows:

- The two inquiry strategies seemed to intersect to some extent. Despite the implicit and explicit incongruities across the domains of purposes/strategies/actions/effects between different parts of the system around 'complex cases', it had been possible to obtain sufficient collaboration around an individual case to arrange a successful admission. There were indications that some individuals in the department may share sufficiently overlapping perceptions of the issue involved in dealing with this type of case to warrant further collaborative inquiry. But Torbert's (1981) requirements for the first stage still remained to be tested - namely, whether the participating parties can come to share the aim of collaborative inquiry and the model of interacting qualities of experience.

- As for the Hermeneutic Dialectic Process, it seemed too early to say. It occurred to me during the mini-inquiry at various stage that it was helpful to have a name for the circular process of gathering different constructions, and in naming it in this way I became more conscious of including constructions of previous 'respondents' into any one conversation. There seemed many differences however. I was purposeful in who I selected; there were differences in power between the 'respondents' (which I was seeking to minimise by putting all on the same level with respect to their involvement in the dilemmas and their possible dissolution); and I did not formally analyse each developing construction after talking to each individual. Although I sought to honour each set of constructions (in so far as I was aware of them) in my analysis, I afforded them different weight according to my purpose which was to rapidly find 'just sufficient enough' agreement to be able to take the first step. In this way there seemed to be an intersection here with collaborative inquiry's experiments-in-practice which is a more discontinuous and emergent process. It occurred to me that perhaps there would need to be many laps around the circle or traverses up the spirals of the Hermeneutic Dialectic Process.

At this point I felt I had now 'sampled' the experiences of working across the whole of the patient journey for 'complex cases' through an episode of inpatient care. I had developed my own understanding of the significant steps and what the issues were at each of them for the client, for myself, and for the various other professionals who would be involved. I now felt I had a tentative 'map' which could guide me towards a systematic and collaborative development of a set of 'good practice' guidelines.

I considered that in terms of a gender analysis, much of what I had done had been in the traditions of agency providing structure in the face of chaos and uncertainty, and in providing a protective space in which communion could occur to mitigate and soften the struggles for control over the definition of realities and ownership of body and identity. I saw myself as seeking communion potentially at work and exercising agency to facilitate its further expression. This was useful to enhance the sense of balance I was looking for in moving between the implicit and the explicit.

To date I had only a global and intuitive sense of how I moved between the two traditions. I will reflect further on this at the end of the next chapter in which I tell of further inquiries with different staff groups towards developing an explicit set of good practice guidelines. In these I learn about the tension between differing purposes - on the one hand developing a body of knowledge through systematic and explicit means; and on the other hand following events in a 'naturalistic' sense in order to foster a wider sense of development towards interdependence, autonomy and self-validation in working relationships. Maintaining my balance across this tension required moving in some unexpected directions.

12. CO-CREATING 'GOOD PRACTICE' FRAMEWORKS: A 'DOWNSTAIRS' SCENARIO.

Introduction.

My intentions at this stage were to use the 'Patient Journey' concept and to use the two inquiry strategies to elaborate each step, as I perceived them to be. I saw two ways of doing this. One was to use opportunities as they arose through my work with individual cases to develop more explicit understandings from the different individuals and groups involved. The other was to initiate in a timely way some more formal inquiries with colleagues, using the 'Patient Journey' concept to aid us in identifying key steps and deriving accompanying 'good practice' guidelines and standards.

These intentions proved difficult to hold onto within the social topography of the department and the multiple demands generated by the delivery of a day to day service while at the same time accommodating to and managing continuous change. I found myself moving across many different territories in carrying out daily tasks while at the same time trying to work towards a manageable balance between stability and change.

In following the thread of 'complex cases' through the fabric of experience I was able to use both the informal and the formal, the implicit and the explicit in making the most of opportunities to collaborate with colleagues towards a consensus 'understanding' about 'complex cases'. However this did not prove to be the systematic experience I had hoped for, and in terms of a set of 'good practice' guidelines, only partial success was achieved over the eighteen month period I am writing about. Further development took much longer and its description is beyond the scope of this thesis.

However I will make a narrative commentary here that patterns of care around the 'management of complex cases' eventually became embodied in a protocol called the 'Role of the Key Worker' adopted within the department after the period covered in this thesis. This protocol did not prescribe how to work with 'complex cases' but it contained a set of negotiated and agreed steps, roles and responsibilities for 'Key Workers' (those clinicians, like myself, who took responsibility for coordinating and delivering treatment and care of individual clients, their families and related professional systems). Such a protocol signalled the explicit recognition of 'complex cases' and some broad agreements about what was needed to successfully work with them. It is the 'ground work' for this I am covering in this thesis.

In this chapter I am reporting on two domains. Firstly I am charting the initial stages of the development of a set of commonly agreed 'good practice' guidelines with colleagues. Secondly I am charting how I managed the tensions and dilemmas of working across multiple purposes, having to 'let go' at times in order to support growth and change, having to 'hold tight' at others to support stability. I came to realise that the focus of complex cases may have limitations as a focus for researching 'what I do as a psychologist'.

In terms of the Hermeneutic Dialectic Process, I saw the need to gain constructions about working with 'complex cases' from the following groups: the ward nursing team; the day care team; the administrative team; and the senior clinicians, including the two consultants, who made the initial assessments and referred clients into the ward for inpatient or daypatient care. I imagined that the Hermeneutic Dialectic Process would provide a conceptual map for moving between these groups as I carried a set of constructions from within one to the other for consideration and elaboration. It was clear that I would not be able to move from one to the other in a linear and progressive way, but rather in a discontinuous and emergent way, working with all groups simultaneously in the course of any one day. I held the use of the process to be useful at a more 'macro level', more in the sense of a spider building a web over time.

I have chosen to cluster these groups into two according to the metaphor used by the nursing team from time to time. The nursing and day care team, who provide 'hands on' care, are 'downstairs'. The administrative staff and senior clinicians are referred to as 'upstairs', the latter seen by 'downstairs' as maintaining more distance from clients who are inpatients and daypatients, but as having more power and authority to determine how that care is effected. This chapter is about working with 'downstairs' and I have chosen events which , in Narrative Inquiry terms, hold the 'why' of the research for me.

I will refer to Rosemary's story from time to time to provide a representative client's 'voice' in each of these groups as the patterns around working with her were ones we became very familiar with in working with others and which informed the eventual 'Key Worker' protocol.

Working with the Ward Nursing Team

Developing collaborative relationships in the setting of the ward nursing team required use of more informal opportunities in contrast to what was achieved later with the day care team. I will illustrate with one such occasion in which I observed a new pattern emerging in our work with Rosemary, and how this was 'cheered on' to become a more regular feature of working with 'complex cases'. Firstly I will describe the setting so as to make available the contexts in which this new pattern was observed and 'punctuated' or made sense of.

The setting.

The ward nursing team was led by Anne, the ward manager, and on any one shift comprised herself and three relatively junior nurses. Anne worked 'nine-to-five' during the week, but the nurses worked a shift system to ensure twenty four hour continuity of care. Therefore the membership of this team slowly and continuously changed as the nurses moved around the different shifts. This meant that Anne was the 'anchor' person and provided the interface between the nurses and the remainder of the staff who worked nine-to-five.

Each patient had a 'named nurse' who was responsible for assessing their nursing needs and planning and implementing their nursing care together with them. The nursing care plan was conjointly owned by the nurse and the patient, and the patient had access to the nursing

notes and could exercise editorial rights on them. When the named nurse was going off her or his shift, the updated care plan was 'handed over' to the oncoming shift which would pass it on to the next, and so it would rotate back to the shift the named nurse was on for further refinement.

There were three global roles which nurses performed: an *independent* implementation of nursing interventions and processes; the carrying out of *delegated* tasks from doctors such as dispensing medication and observing signs and symptoms to aid their diagnoses and treatments; and an *interdependent* role in which they collaborated with other members of the multidisciplinary team in designing and implementing other treatments or interventions.

During detoxification of patients, the nurses mainly occupied the independent and the delegated roles as the primary focus was to support the patient through the physical and psychological distress arising from withdrawal from drugs or alcohol. This was the most time consuming aspect of their work and often the most demanding. When patients stayed on the ward after their detox was complete, if they required further work in preparation for discharge, then the nurses moved more into their interdependent role. While it was the nurses' job to provide a twenty four hour supportive environment, the responsibility for care planning in this later stage rested more with other team members who were working with the patient. The nursing care plan at this stage was about how to provide an environment in which this later work could successfully take place. The named nurse may take a variety of roles at this stage, according to the purpose of the patient's stay and the requirements of other staff members. One of the key differences between nursing and other disciplines is that a nurse on a ward is required to 'be with' patients continuously and hence they develop different relationships with different nuances and textures than do other disciplines. This requires an ability to both 'get alongside', and at other times set and apply limits about behaviour which may require challenge and even confrontation.

In the earlier days of the department's life, there was less agreement amongst members about how long and for what purposes patients should stay after detox. The priorities tended to be set by the demand on beds and how quickly they could be emptied to allow new patients to be admitted. Patient's tended to stay on if they were waiting for accommodation, if they required further assessment of their physical or mental state upon becoming drug or alcohol free, or if they were particularly vulnerable because of social or psychological problems which needed addressing immediately. The extended stay tended not to be planned for until admission, and the period after detox tended to be ripe for confusion about 'who was doing what with who'. In this context nurses could find themselves carrying a range of tasks and roles, as much by omission rather than commission on the part of others. This rendered them vulnerable to criticism from other disciplines - for either doing 'too much' or 'too little'. This was my understanding as an 'outsider' but based on close interaction with nurses over the years. I have noticed often that nurses tend to occupy one role more than others, according to

personal preferences, skills and experience, and the requirements of the setting in which they work (including other disciplines' understanding of nursing and their requirements of it).

Managing the boundaries.

In developing 'good practice' for 'complex cases' I saw the challenge for myself as supporting the nursing team in creating a twenty four hour environment in which the goals of the initial broad admission care plan could be pursued. This support needed to recognise and affirm the variety of roles the nurses played, needed to allow for individual differences in the nurse's interests and competencies, while at the same time creating a 'space' in which I and other disciplines could work with the client. This required a balancing act between differing world views - ones which arise because of individual differences and ones which arise through different organisational and professional roles.

Practically speaking, this meant that there needed to be a degree of congruence between the nursing care plan as independently done by the nurses, my initial broad care plan about the overall purpose and goals for the admission, the particular work I did as a psychologist with the client, and the views of the client themselves during the admission.

In practice in the early stages, I found myself taking on a role of 'managing the boundaries'. In other words, keeping a noticing eye on 'who did what with whom' and ensuring that as far as possible there was clarity around how individuals participated with each other and that this participation was openly negotiated. One of the boundaries I wanted to respect was the one around the nursing team. Ann led this team and she was responsible for nursing care on the ward. I wanted to support her leadership. On the other hand I also wanted to make sure client's needs were met and I was prepared to advocate for them if need be.

I will illustrate how we began working towards developing congruence through being more inquiring of each other, and demonstrate the role I played in marking and respecting boundaries by drawing from an incident during Rosemary's first admission

Rosemary's story - roles, boundaries and inquiry.

On Rosemary's first admission she settled into a pattern of spending most of her time on her own, writing, drawing and meditating. At that time there was not an organised programme of activities and she had elected to do little with the newly arrived occupational therapist and physiotherapist. Her named nurse was to provide her with counselling support when she needed to "sound off", when she felt lonely at nights, and with general problem solving about being on the ward and negotiating use of the resources. Rosemary had regular and frequent sessions with me, spent some of her time talking with other patients, and some of her time out of the hospital grounds dealing with practical problems about her day to day life. She was often distressed but did not like others to know it.

The first challenge came when she returned mildly intoxicated from a visit home. This put the nurses in a bind as alcohol consumption during an admission was clearly forbidden and was

grounds for discharge. On the other hand they were unsure about whether to exercise this limit as Rosemary had more complex problems and they were aware she was here for us to assess how we could work with her. Ann took me by surprise by approaching me about this before making any decision.

We discussed our respective perspectives. I was willing to advocate for her staying and using it as an opportunity to understand more about the meaning of her alcohol use. But I also wanted to respect that the nurses had responsibility for the whole patient group and knew what the presence of someone smelling of alcohol and appearing intoxicated could mean for them. I expected Ann to take this view and push for discharge. However, she said she had an instinct not to do this. I inquired into the instinct. Ann felt that Rosemary was ambivalent about being here and by overtly coming onto the ward mildly intoxicated was 'inviting' us to discharge her. If we did so, then we would be the 'baddies' and Rosemary would not have to take direct responsibility for leaving. Furthermore, she recognised Rosemary's capacity for seeing blame in any confrontation and the potential for escalation of self-destructive behaviour which would likely ensue. We discussed this further, and together developed alternative ideas, for example that she might also be testing 'how safe' she was with us. Were we going to tolerate her distress and provide safety without control? And so on. We discussed these ideas in relation to observations we had made of her interactions with others around the ward so far and decided this idea had a contextual appeal. We talked with the named nurse and agreed to let Rosemary stay, but decided that she could only come onto the ward when her breath alcohol reading was nil.

We all inquired the next day with Rosemary into her drinking and on the basis of the discussion together made some small changes to her care plan and re-negotiated the respective roles we would play - to whom Rosemary would go for what sort of problem and support. Rosemary drank again on a further occasion a week later and this time I heard about it after the event. Rosemary had told her nurse directly and offered to spend the afternoon in the grounds of the hospital before coming onto the ward. The nurse had let Rosemary into her room and allowed her to 'sleep it off' provided she did not come out of her room until the nurse agreed. Together Rosemary and the nurse inquired into this drinking incident afterwards and tried to make sense of it in the context of her relationships with men and her confusion in establishing manageable levels of closeness and intimacy with them. This began a relationship in which Rosemary started talking to another woman for the first time about issues of gender and sexuality.

Lessons taken.

This was the start of a pattern in which the nurses both maintained a set of rules (necessary for structure and stability) and at the same time inquired into any challenges to them in the context of the individual patient's life and in the context of the relationships within the ward (necessary for change). I saw this as the beginning of a new inquiring interpersonal strategy and sought to support it where I could. It was also the beginning of the nurses extending their

interdependent and independent roles through a more explicit negotiation process which involved the nurses, the client and myself.

I sought to support this newly emerging pattern by:

- Discussing initial admission care plans routinely with Ann and the named nurse.
- Having named nurses attend my initial assessment sessions where possible.
- Attending nurses' hand-overs between shifts when close support was needed.
- Convening regular small 'review' sessions with the named nurse, client and other workers involved.
- Providing ad hoc consultation and supervision as requested.
- Attending the large weekly ward rounds to support the nurses in presenting their work to the whole multidisciplinary team, coaching them before hand and providing re-framings in the meetings when it seemed the consultants were not able to fit the nurses' work into their own frames of reference.
- Sometimes 'getting in the way' by challenging when I perceived that they were letting others 'take charge' of their work, or when they were extending themselves into other disciplines' roles.

In all of these interactions, I would link with Ann at some point to keep her 'in the picture'. There were occasions in which Ann would try and formalise some of these arrangements into regular time slots with regular membership, but these never succeeded. It seemed that in this setting, with changing membership and with the priority being to respond to patient needs moment to moment, inquiries worked best 'on the spot' when required in a less formalised way.

The key process I saw evolving within this group as being significant to 'good practice' with 'complex cases' was that of negotiation about roles and style of involvement. There was a wide range of skills and experience among the nursing team and this was the start of a more negotiated involvement between nurses, clients and key workers according to age, sex, interest, skill level and client preference.

Working with the Day Care Team.

Within this setting I also played a role of 'keeping an eye on boundaries'. The process I will describe is one of continuous experimentation and evolution to find a form of providing a day care programme of activities and interventions which provided a 'fit' between the requirements of the clients, the staff and the overall pattern of service delivery within the department. It was within this setting that I also kept a 'noticing eye' for the possibilities of developing a cooperative inquiry group. I will firstly describe the setting and then how we inquired together to develop some further steps along the 'patient journey' for complex cases, together with some agreed processes for managing them. The workers in the day care team could structure their time with patients differently than the nurses, so a more formalised inquiry became possible. However, that had a surprising ending for me.

The setting.

At this point in the department's history, a more structured day care service was developed. This was provided by an occupational therapist, a physiotherapist, a part-time nurse with counselling experience, and supported and coordinated by Ann the ward manager. I will give a brief history of the development of this day care team as a backdrop to understanding the work we did together.

As a department, we had attempted several such programmes from the outset but had failed for many reasons. Among them was our inability to involve clients successfully in a routine timetable of fixed activities. When I joined the department at the outset, there had been an occupational therapist who provided a programme of leisure, occupational, educational and interpersonal skills training. She was not employed by us and was managed from within another department.

This programme was pronounced unsuccessful by all. Some clients saw it as being irrelevant to their needs and refused to attend, others saw it as relevant in parts but attended all only under pressure from the nurses. The nurses resented the conflict they encountered in trying to convince clients to attend, and felt excluded from contributing themselves because of their shift system. The occupational therapist resented the nurses not doing more toward the programme and felt they did not provide sufficient encouragement to clients to attend. Her being managed from outside our department precluded the flexibility that was required.

When she left there was wariness all round about asking again for occupational therapy time in our department. Within the Core Group, we developed ideas about what was needed to succeed in the future. We wanted a range of interventions which would be applicable to the broadest group of clients to help them cope successfully with life stresses without relying on drugs and alcohol. We considered how we might organise these so that they meshed in successfully with other treatments and activities.

Most of the interventions we decided upon were psychological in nature, and could be grouped under the categories of problem-solving skills, stress management and interpersonal skills training. These would need to be supplemented with leisure and recreational activities, and some physical therapies such as massage and exercise. In our discussions in the Core Group we had identified that the key requirement was to have these available as 'packages', to be used flexibly according to the needs of the client group at any one time. Past experience had shown that clients attended for different reasons and for different motivations. A fixed daily programme met the requirements of staff for stability and predictability, but not the requirements of those clients who saw little relevance in it and refused to attend. We needed to be clear among ourselves about what choices we were providing, so that in turn we could be clear with clients, and so prevent on-going conflict during their stay about differing expectations. I jokingly called this the "Cafeteria approach", where we provided a menu from which clients could choose, with our guidance.

We were eventually able to obtain funding to employ our own occupational therapist and physiotherapist, to be managed from within the department. This structural arrangement made us feel more confident we could develop an appropriate day care programme this time around.

Inquiring together about day care.

Following the failure of the early programme, some day care groups and activities had been provided by several of the nurses from the ward, supported by me through consultation and supervision. There had been experimentation with the form, the content and the timing of these activities, so some baseline knowledge existed about how to implement the 'Cafeteria approach'.

The arrival of the occupational therapist and the physiotherapist signalled the need for change in roles within the nursing team. It was assumed by the Core Group that Ann would take responsibility for negotiating with those involved and I did not anticipate that I would need to be a part of this. However, this was not to be so. Ann requested me to meet with herself, the occupational therapist and the physiotherapist as she was having difficulty negotiating the changes.

On meeting with the three I felt a tension in the room and I observed that they were very tentative with each other, nobody stating openly what the agenda of the meeting was nor taking the initiative. I wondered what was restraining them. Was it that the two newcomers had had little experience in this field and were tentative about taking the initiative? Was it that Anne was ambivalent about the changes? Or was it that she did not have a vision herself of how the day programme could work and could therefore not provide a framework within which the two newcomers could orient themselves and begin contributing? Was it in this way that they together lacked a wider context or frame which they shared which would support inquiry and collaboration? I decided the latter assumption would be the most productive to pursue.

I inquired whether the purpose of the meeting was to discuss how the occupational therapist and the physiotherapist could take over responsibility for providing the day care programme with support from the nurses. There was a noticeable lowering of tension. The occupational therapist and the physiotherapist nodded as if that was exactly the case, and Ann sat back in her chair with a look of relief on her face. I offered to give a brief historical outline from my perspective on how the department came to this point and what the expectations were for the day programme, thinking that this might provide an initial frame for further dialogue and negotiation. This offer was accepted and I told them the story of the 'cafeteria approach' to day care. The dialogue flowed from that point. Following this meeting I retreated to a more distant stance, assuming they were now 'on the move' but nonetheless ready to move in 'close' again if needed.

As the occupational therapist and the physiotherapist developed a 'menu' of activities and experimented with how to engage clients, they became clearer about what they could offer

and more confident about negotiating with other colleagues. In my role as case manager of 'complex cases' I involved them routinely in mini-inquiries around individual cases.

As their confidence grew in their roles, the day care team began expanding their range of interventions and developed special interests such as pain management and acupuncture. As with the nursing team, I wished to support this development by keeping a 'watching eye'. I wanted to ensure that activities were grounded in sound psychological principles and practice while at the same time the individuals felt that they 'owned' the programme and made full use of their competencies. My intentions were to do this gently and through collaborative dialogue. In this way, our interactions with each other around case work were infused with this intent. But I also made it clear I was available for supervision, consultation and support in other ways.

As this pattern of work became more consolidated, I received clear feedback that they liked the role I played. Specifically, they liked the care plans I drew up, they liked the 'mini-inquiries' with clients, and they liked my "sensible suggestions" and availability when needed. They appreciated being able to develop their own roles and style of practice. This seemed to be a similar pattern to the one which had evolved in my work within the nursing team.

To my surprise one day the day care team suggested we all meet together weekly to review clients collectively and 'trouble shoot' the programme. I responded enthusiastically as this seemed to be a move to another level, of inquiring together collectively rather than in dyads or triads. It offered a more systematic development of a consensus understanding about day care to clients, some of whom were representative of 'complex cases' such as Rosemary.

We started by discussing individual clients and ensuring that there was clarity about their care plans and coordination between all those involved in delivering care. In so doing, we began to notice patterns in the nature of problems which arose. The major source seemed to stem from other clinicians in the wider department referring clients to the ward for day care but supplying insufficient information, making inappropriate requests, or failing to be available when needed for longer-term planning. Or alternatively, clients were being referred to the ward by outside referrers, such as other hospitals, but not having a named worker assigned within the department from the outset who could take overall responsibility for care-planning and follow-up help after discharge. We realised that this was 'true' for all cases irrespective of degree of difficulty or complexity. To this point, I had bracketed off my interest in developing 'good practice guidelines for complex cases'. Now there was no need as we were discussing basic principles central to good practice with all cases in terms of providing day care activities.

As we paid attention to this pattern and discussed it further, we began deriving a list of activities and events which were seen as critical to a successful transition through the day care programme. Up to this point I had participated as another clinician with a direct involvement with some of the clients, and as a member of the Core Group concerned with supporting this group in owning and delivering a quality service. I was reluctant to impose any structures which did not 'fit' with this purpose. However, at this point I saw the concept of patient journey

as being highly germane to what we were doing. It also had relevance within the broader 'Quality Assurance' remit we had been given by central government. It seemed timely to introduce it here. I also had rising hopes of this being a setting in which I could introduce a 'research' frame and invite the group members to form an inquiry group and explicitly explore some of the research strategies in our work together - but this seemed still slightly premature and I decided to leave this for a little while. First things first.

For the next two months we meet weekly and gathered data from our day to day work and brought it to the group to reflect on and to use in developing our own 'map' of the patient journey through an episode of day care. By this time, Rosemary had had several admissions and we had all worked with her to varying extents. We used her and several other clients to refer to and explore the implications of a patient journey approach. I had asked Rosemary to evaluate her admissions in terms of the goals she had set for herself, to what extent she had reached them, to what extent she had found the process of care helpful, and what could be changed to improve things. I contributed these data to the discussions.

Once we had developed a tentative map with which we all agreed, we went through several cycles of taking this map out to other members of the department, interviewing them about it and incorporating the feedback into a more embellished form. We used the idea of the audit cycle to inform this process as it was one which was closely linked to the concept of the patient journey. We called this 'map' a protocol, containing the significant steps along the patient journey, with standards and guidelines for each. Central to this was the idea that one person needed to retain responsibility for accompanying the client through this journey and this protocol outlined what those responsibilities were. This role we called 'Key Worker'. At a later date it was to be adopted across the department and extended into new services with which several of the senior staff, including myself, became involved.

Unexpectedly, this process had mapped the views of a wider range of colleagues than I had anticipated in my earlier thinking about 'good practice' guidelines. The community team and the senior clinical nurses from 'upstairs' had been included in this process. The two consultants had not as they were not seen as occupying the key worker role at this time. Although the process was aimed at making the jobs of the day care and nursing teams easier, it also began raising the issues for other staff who referred in to the ward. I saw this as being a useful focus for further inquiry with senior colleagues.

By this stage my hopes were rising that this group could easily become a Cooperative Inquiry group within which we could extend our work to inquire in more depth around 'complex cases'.

Then the group members took me by surprise yet again. They told me that they had decided to use our meeting time with the ward nursing team instead. They perceived them as needing support in dealing with problems they were facing and the only possible meeting time coincided with ours. They offered to negotiate an alternative meeting time but we could not find a mutually suitable one. I then suggested that we should discontinue - after all, we had almost

completed our objective and I could finish off the protocol myself with the information available. There was no protest at this.

Lessons taken.

• Personal/Professional.

I had mixed feelings. Partly I was a little insulted that they had done this unilaterally. On the other hand, their decision signalled a transition in their relationship with the ward nurses. As they worked alongside each other everyday, it was important that they began sharing more closely the responsibility for managing the ward environment. The day care team joining with the nursing team was a more natural 'sub-system' than their continued meeting with me. I felt pleased at this development. I had a wider set of responsibilities which required me to move across different groups and my place was not as a permanent member of this sub-system.

My view was that if issues arose in the future which required a regular involvement from me for a while, then we would re-negotiate how to achieve that when and if it arose - it would emerge naturally. It was time to 'let go'. What we had created together was solidly grounded in our own experience and incorporated the views of other members of the wider department. On reflection, we had developed a much more detailed 'map' about 'good practice' than had existed previously, which indicated the steps on the journey with some guidelines on how to negotiate them. Others ought to be able to follow this map, with some initial guidance. I could offer such guidance to colleagues outside the nursing and day care team, and at the same time invite collaboration in further embellishing the map. Even though others' views had been actively sought and incorporated into the 'map', it would be only by using it in practice and 'walking' the paths themselves that colleagues would become active participants in negotiating this 'territory'.

• Inquirer/Researcher.

In terms of Collaborative Inquiry I saw us as having got to 'first base' in agreeing a focus for working together, beginning to make explicit our purposes and strategies, and relating these to outcomes. However, we did not get to second base in terms of explicitly agreeing to inquire together in terms of using the model of interacting qualities of experience and agreeing to collect on-line data about our own experience. The model remained useful to me in guiding my own actions and awareness, but not in sharing with others as a model to guide inquiry.

The Hermeneutic Dialectic Process remained useful as a macro-map to keep me alive to the importance of weaving together constructions about 'complex cases' from the different groups. However, I was beginning to feel that the focus on 'complex cases' was not going to serve as a means of holding all the research strands I was carrying. I realised from the dissolution of the group meetings that I was unlikely to obtain the kind of explicit co-researcher/co-subject relationships I was seeking. This was remaining a personal journey. I could see that the development of a set of consensus understandings about complex cases was going to be a discontinuous process and that I was not going to suspend personal learning and inquiry into

my practice in the meantime. Similarly I was not going to suspend my clinical work in the meantime - I was going to carry on and be prepared to pick up the strands in a timely way when they surfaced again. I was more curious about the patterns of relationship which had emerged 'downstairs'.

Reflections on 'downstairs' inquiry.

In reflecting on the patterns which had emerged in working 'downstairs', I was drawn back to Marshall's (1984) conception of agency and communion as providing an explanatory and descriptive 'fit'. Her conceptions of action from within the two domains constructs the agentic as 'doing' by internal, personal objectives, engaging in idealisation and trying to change the environment to match its own preconceived images. By contrast, communion is directed from its open contact with and appreciation of the environment, and action is mainly context-motivated. Prior acceptance of the world-as-it-is results in action which is in tune with the surrounding context, but is not conceptually premeditated. Therefore action based in the communion may be highly appropriate as a result, but it also risks being too thoroughly shaped and determined by the environment.

The agentic mode is based on the principle of independence, whereas communion is part of a wider context of interacting influences. I saw myself as moving between these two modes. In relation to boundaries around the ward I tilted toward the agentic in terms of supporting sufficient independence of the surrounding environment to allow communion-based action to flourish within. I did this in relation to referrers' framing of the problems and solutions (as in Rosemary's case), and in relation to the two consultants in ward rounds who similarly adopted views of problems and solutions which were independent of any inquiry into the views of clients and 'downstairs' workers. My role had been to maintain boundaries by reframing problems to the degree that sufficient interdependence could be maintained which supported the various actors in doing their work from a position of personal authenticity. In that role I could be assertive and 'hold my ground', although not in a fully agentic sense of making attributions about causality and outcome which were context-independent.

Within the 'downstairs' team, I tilted more towards communion. To this extent I was willing to go with what emerged and depart from pre-conceived notions of 'how things should be'. However, I did have certain pre-conceived notions from which I was not going to depart easily but they tended to be more process variables (such as boundaries, negotiated roles and so forth) rather than outcome variables. I was able to let go the unfinished 'good practice' guidelines (a hoped for outcome) because I afforded the processes which occurred around their production a higher value than the finished tangible product itself. There have been times since then when I have wondered about this, thinking that the finished product would have been useful, and liking to have tangible outcomes which give rise to personal satisfaction. However, more recently the 'wheel turned full circle' and there was a revived interest from both 'upstairs' and

'downstairs' in finishing these. In this context of interest from others, it became more easy to complete.

Marshall's conception of the role agency plays in relation to communion captured the spirit of what I had been trying to achieve, namely: protection for communion's vulnerability in hostile or new environments; creating structures within which communion can operate; supporting communion by giving it direction; affording a systematic understanding of alternatives within which communion can locate itself; and helping translate communion into direct effects through judicial instrumental action. Within this understanding, I became more accepting of the way my inquiry was heading, letting go of the idea of a formal inquiry group.

Activity within the tradition of agency, by its very nature, is easier to describe than activity from within the communion which is more context-dependent and muted. In the next chapter I tell of how I worked with 'upstairs' staff and discovered personal limitations of trying to operate from within this model alone without an explicit awareness of power issues in relationships. It is perhaps no accident that 'upstairs' we were all men, with the exception of Jan and the administrative staff. I found I needed to move away from the focus on complex cases in seeking to develop a more mutually inquiring relationship with William.

13. SEEKING MUTUALITY AND CONFRONTING POWER: AN 'UPSTAIRS' SCENARIO.

Introduction

While working with the 'downstairs' staff in developing 'good practice' frameworks, I was simultaneously working with the other senior staff 'upstairs' in finding new markets for the department's services. This activity surfaced issues of power and difference which took precedence over clinical work. Although the marketing process led to a more elaborated 'map' of the patient journey from point of referral outside the district, this was overshadowed by tensions within the group. It is these tensions and my dealings with them which I wish to present in this chapter. I will report one particular meeting as being the point at which I recognised the need to take a more active role in the team, and to develop a different relationship with William. This relationship leads to the need for me to re-conceptualise power.

In reporting these events I move away from a direct focus on complex cases to the issues of seeking mutuality in a relationship with a male colleague and the personal learnings this leads to. Although I retained an active interest in developing 'good practice guidelines for complex cases', and although the events reported in this chapter helped towards their elaboration, I am now departing from this as a focus for the research. I retained the notion of the Hermeneutic Dialectic Process as a macro-map for gaining constructions from different groups and, within this map, spent time with the administrative team devising a parallel administrative protocol for supporting the clinical process for 'complex cases'. The 'management of complex cases' eventually became a recognised part of our service which was successfully marketed and contributes to our income generation. However, I am not reporting these later developments as they became peripheral to the developments reported below in relation to my research interests and purposes.

Marketing: tensions and possibilities.

The group of people who came together to develop a marketing strategy comprised the Core Group, Ann the ward manager, and three senior nurses who had previously held regional roles before the health reforms. Gerry, the most senior clinical nurse, was among them. These 'regional' nurses continued to do work with cases referred in from other districts, but their roles required re-defining in the light of the changes. This group contained all the people that we considered as having roles extending beyond the delivery of the service to our local health authority. Looking at this another way, we were the individuals at risk if we were unable to find new purchasers. Therefore, we were the individuals who needed to be involved in developing a marketing strategy to secure these new purchasers.

As a large group we had not worked together in any sustained way before. Within this group however there were sub-groupings of individuals with a history of working together, and who brought the patterns of relationship which had evolved from that history. There was the core group, with our history of several years of meeting and inquiring together within the limits of our professional roles and personal motivations. There was the group of regional nurses who

often felt the 'meat in the sandwich' between the respective views of our service and those they liaised with around the region. And there was Ann and I with our history with the nursing team and the day care team.

In addition, we had two marketing consultants coming in from 'outside' as experts. This added another dimension to the dynamics of the group, with a range of responses from willing acceptance of outside expertise on the part of Jan and myself to barely veiled scepticism on the part of Stewart.

We were united as a group in our perception of the need to make changes, but we were varied in our views about how that should be done. Once underway with the process, three main options began to emerge as strategic developments suggesting further inquiry. The first was to consolidate our existing contracts. All but the two medical consultants felt there was considerable opportunity to secure our contract with existing purchasers over the longer term by improving the quality of the existing services.

The second was to develop a short term rehabilitation service of six weeks duration for people requiring medical, psychological and social interventions following detox from drugs and/or alcohol. This was to be a highly planned intervention aimed at individuals with specified problems whose needs would be carefully assessed prior to admission to the programme. Such a service could be achieved by reorganising existing resources. In marketing terms it was 'new product for existing customers'. William the clinical director was particularly keen on this. The third option was the development of a completely new venture, a convalescence service providing psycho-social support for people recovering from episodes of major physical illness. Stewart was particularly keen on this but supported by William. This would be a 'new service for new customers' and would take us outside existing patterns of service delivery, requiring the Trust executive group to provide bridging finance. It was a high risk option which did not take into account the existing skills and career pathways of the majority of the staff.

The provision of a service for 'complex cases' was an invisible fourth strand. It was implicitly known by Jan, myself and Ann that we were developing expertise in doing this work, but as yet it was not explicitly recognised by the two consultants. In this setting there was little chance of introducing the concept and having it accepted by the two consultants who would not perceive themselves as being the major 'stakeholders' and would therefore 'squash it'. This fourth strand required painstaking and 'hard' work whereas the two consultants had made it clear that they were not interested in new developments which were not "fun and life-enhancing" for them.

Over the course of six months, many members of this group had put in long hours and hard work doing market research, using the structures and procedures provided by the marketing consultants. In doing so we had learned to look at our department through the eyes of others. To some it was a revelation, realising how "ethnocentric" we had previously been. For me it

further strengthened the idea that we had something unique to offer in 'management of complex cases'.

As this first phase of the marketing was drawing to a close and decisions had to be made, issues of power moved from the realm of the implicit to the explicit in a very public way. This was revealed in a half day meeting between the group and the two marketing consultants who were going to take us through a complex decision-making process to arrive at key objectives and priorities.

The personal significance of this meeting was that it awakened in me the realisation that I had to find a way of directly involving the doctors in what I was trying to achieve. It was no longer possible to 'skirt round' them and hope that my work would succeed. However, at this stage I did not wish to view the relationships in terms of power. Firstly, I will tell the story of that meeting as I wrote it shortly after the event, reconstructed from my reflective diary on the day and from field notes made in the meeting. Then I will reflect on its implications.

An Awakening.

Marketing meeting: Present were Jan, William, Stewart, Gerry, Luke, Paul (three senior nurses) myself, and Steve and Bob the two marketing consultants. Ann (Ward manager) was not present.

The planned purpose of the day-long meeting was to evaluate a range of options for new markets for our service which were to be part of a final marketing strategy. A paper had been circulated prior to the meeting with nine different options we had generated out of previous meetings. I had not brought my copy with me and had not read it previously, so quickly read one belonging to someone else.

As the meeting started I was finding it difficult to concentrate on the business at hand, still being preoccupied with several pressing problems I had been presented with on arrival at work that morning for which I had hastily organised temporary solutions until lunch time. Behind that again was a tiredness and preoccupation with other things - preparing teaching sessions until midnight the previous night, trying to find time for research writing over the last two weeks, and feeling like I was not 'up with the pace' at work.

Steve the marketing consultant began with a lengthy explanation of the process for the day which would culminate with a data set he would then run through a computer program. I was not following this fully but assumed this was due to my preoccupation with other things. I remember saying to myself, "just listen carefully and it will eventually come clear, and anyway its nice to sit back and let someone else take charge. Steve often begins like this and eventually we manage as a group to get a workable process going."

Bob was unusually quiet and appeared withdrawn. His face was pale and gaunt and I assumed that he was in pain as I knew that his back problem had recurred recently. We had swapped 'bad back' stories.

After Steve had finished describing the process William summed up the goal for the day as "developing a shared understanding" of all the options we had generated so far then agreeing an order of priority. Stewart then declared that we should only consider the first three of the nine options. These were the ones concerning provision of new services only. The remaining six concerned developments of existing services. In the last meeting, at Steve's suggestion, we had grouped these options as requiring different strategies.

At that point Jan intervened and challenged Stewart by stating that we could only develop new services to the extent that we managed our existing ones well and held them alongside any consideration of proposed change. Steve supported Jan by affirming that our existing purchasers remained the most important. Stewart said yes he agreed but that it was not important for this exercise, we had to do that anyway and it could be left for some other occasion outside these meetings. Then followed an escalating interchange between Jan and Stewart which William quickly joined by declaring also that we should only consider the first three. At around this point Stewart personalised the argument by stating that he thought Jan was "wilfully misunderstanding" him. Jan replied to this by stating what she understood Stewart's views to be, how hers differed from his, and ended by observing that it seemed to her that they each shared different values about what was important.

At some point around here I intervened. I was feeling confused about the issue of whether there had been a previous agreement to only focus on certain options, not having read the paper beforehand and with both William and Stewart behaving as though this were the case. But I also felt that staying with what we were doing as an option had to be considered alongside any new options as anything new had to be strongly rooted in what we had achieved so far (even though we were losing contracts in spite of having performed well, leaving us all feeling rather helpless and discouraged). I could see that Jan was feeling stunned and bruised by the encounter and I was surprised that William had joined so strongly with Stewart. I was not surprised at Stewart's stance as he had made it clear at the beginning of the marketing project what his agenda was and had entered the process reluctantly. I had also seen the conflict before between Jan and Stewart in the Core Group over management issues, where Stewart would overtly belittle any efforts by others where he was not in control or which endeavoured to develop more interdependent relationships with other individuals or departments in the Trust.

I was feeling anxious at this stage that the process seemed to be getting out of hand. I saw that Jan was silent and sensed she was feeling wounded . I felt hurt for her and I was worried also that if this process continued we would end up down some road that I would not feel comfortable with and be able to work authentically with. I had entered the morning relying on

the process to help me gain a sense of focus about what we were trying to achieve for the day and I was beginning to see that this was unlikely to happen without some effort on my part.

I was wanting to get some balance back into the process, to bring my self out of my wooliness and to find some way of supporting Jan back in. I commented that I thought we had been invited to consider all the options and that as it was important to gain a 'shared understanding' we should start with getting this clear. William interrupted vehemently that "we have not been 'invited' to do anything, we are in charge of this and we will do what we want!".

There was silence. Steve was looking very tense and suggested we continue with the task, watching the two doctors carefully and not paying much attention to the rest of the group. I was feeling stunned at William's joining so heavily with Stewart. I had not seen him do that for a long time. I did not know what to say and felt we had been 'rail-roaded'. None of the others in the group (three men who were nurses) had spoken so far this morning but acquiesced with Steve continuing with the task as Stewart and William had defined it. Jan also acquiesced but was looking stunned, upset and vulnerable.

As we continued there was little participation apart from William and Stewart. Jan was completely silent. I could not concentrate on what was being said as I was engrossed in my thoughts, reflecting on what was happening and what could I do about it. I wrote down on my note pad:

> *"If we don't attend to existing purchasers and get a clear understanding of what is required we will not know what resources are available to pursue other options. A lot of management resources are invisibly used without people being fully aware of what goes on. There is no inquiry here. How do I inject inquiry? How should I have managed that?"*

I tried to think through what I could have done/could do. The thought 'there is no inquiry present' stayed in the forefront of my consciousness. I was aware of the following stream of thought:

> *" From my experience of Stewart, if I had inquired more of him he would have either retreated more into his determined position or collapsed and gone along with the alternative with bad grace, and that would still leave us being organised around his position. It would have been far better to have joined with Jan and supported her by inquiring more fully and helping her elaborate her views so that they were fully available for the group to consider. It is too late for that now, my fear is that it would look as though I was rescuing her and that would be demeaning of her. Also I do not want to put her on the spot again as she looks withdrawn and extremely vulnerable. I need to find a way of stating my own position, perhaps by declaring my own discomfort at the way the group process is going. That feels too risky as I don't think anyone but the doctors will respond and I won't be supported by the silent members. I feel too vulnerable to cope with that possibility at the moment. The two doctors have used the*

power of their position to push their own agenda. I am confused about what that agenda actually is at the moment but it feels as though its about keeping control of where we go. Steve and Bob have colluded with this. I wonder what they think is happening. Where is Bob? He usually comes in at the point of conflict to smooth things over.

Perhaps I can put my own discomfort aside and go along with the direction the doctors have taken us. At some point we will have to come back to considering the other options. It is not possible to solely pursue their favoured direction of developing services independent of the Trust and its existing service agreements. They believe we are far more independent of the Trust than we actually are. We have explicitly tested this out over the course of the marketing but they do not wish to acknowledge this. This course feels the easiest but does not feel authentic. I do not know what to do."

By then I noticed that William did not look at all relaxed and the level of participation was still very low, with Steve doing an increasing amount of talking. Suddenly William declared that we should stop as "this is not working and some people are obviously unhappy". This was said in a slightly resentful and accusing tone.

Without thinking I quickly interjected, saying I was really glad he had brought this up as I was feeling the same way but had not known how to express this. I noticed that he visibly relaxed as I said this. I went on to say something about the process needing to be more inquiring and respectful of peoples' contributions, and that the marketing would only work to the extent that the outcome represented a consensus. I do not remember clearly what else I said because the next event captured all my attention. Stewart directed a critical remark to Jan, at which point Luke, who was sitting next to her, suddenly leaned forward in his chair and taking his glasses off confronted him by saying that he was "rail-roading people". Stewart retorted and Luke replied: "You are doing it again. You have been doing it a lot. You have a lot of really good ideas which I value hearing but you do not listen to anyone else. I have made a number of suggestions throughout these meetings which go completely unacknowledged by you or are put down by you , so I have given up saying anything!"

Stewart adopted a bodily posture as if prepared for fighting and said: "OK, if it is resentment time let's get all the resentments out . Come on let's hear them!" Luke refused the invitation, replying that he had said all he wanted to say.

William then intervened by offering to include the other options as "obviously some people consider them important". Again, this was said in a slightly resentful manner. Stewart turned away in his chair shaking his head while concurring with a gesture which said 'I will do this to humour you and keep the peace.' There were one or two murmured comments agreeing that we should move forward, including the other options.

Steve, who had retreated to the back of the room, stepped forward again to the flip chart and offered that he may have been the cause of confusion by suggesting the options be grouped separately. In reality, he said, they all needed careful consideration for the purposes of developing a marketing strategy. He was anxious that we move on as time was very limited.

At this point I was afraid Steve would focus back on the task without giving us an opportunity to deal with process. My instinct was not to focus on the conflict again at the interpersonal level but to address the issues at the group level. Despite the extensive work the nurses had done on this strategy, they had largely remained silent in the meetings while the doctors' views remained ascendant. The doctors had frequently doubted or challenged the methodologies and the marketing consultants had taken pains to bring them 'on board' but in so doing had increasingly moved toward a leader-centred style of running the meetings in an attempt to keep control of the process. Correspondingly, they tended to speak more to the doctors than anyone else. This was no longer working and Jan and Luke had finally challenged the doctors openly.

It seemed to me that if we could not create a process which affirmed the contributions of all then the whole venture would collapse. I strongly did not wish this to happen - the future of myself and others was at stake here.

I interrupted Steve, affirming what he and William had said, affirming his wish to keep us on task within a very tight timetable, but expressing my worry that the task would not be achieved if we did not pause for long enough to address the process. I observed that the interchanges so far had only involved half the group and said that I wished to create an opportunity now for the others to offer their views on the process and how they wished to proceed.

There was a brief silence, then Gerry spoke. He said something about other people's resentments, which I do not clearly recall, and then about how he had felt lacking in confidence in putting forward ideas and so had remained silent. I wanted to affirm his experience of feeling silenced and so amplified this by responding that I had felt the same at times and hoped we could support each other in contributing.

Paul followed by saying that he felt no need to say anything at this stage but would be happy to if any one wished. I responded that I would like to hear. He made no reference to conflict or personal discomfort, saying only that he was happy enough to proceed, including the other options in the decision making process. There was no further comment and I felt I had gone as far as I could in creating an opportunity for people to speak. William then took charge of the meeting by going to the flip chart and suggesting a way forward.

As the rest of the morning progressed I felt myself more fully present in the discussions and noticed that the level of participation was increasing. William and Stewart offered more acknowledgement of others' contributions, although making jocular comments to each other

indicating their preference for some options and their dismissal of others. Jan gradually came back into the discussion but continued to look vulnerable and subdued.

I was interested to note that as we went through the sophisticated process provided by the marketing consultants , teasing out criteria for making judgements , gaining agreements on them then assigning personal and group weightings to them, the options the doctors had previously wanted to exclude increasingly 'gained weight'. I wondered if the strategy of 'going with it' I had considered earlier may have worked after all? But I concluded that living things only 'gain weight' when nourished.

Over the course of the following few days, I wrote about this meeting extensively in my reflective diary. Following are my reflections after the action as they occurred to me over those several days.

Reflections on action.

- I think this is 'Action Inquiry in action', that is, use of reflection-in-action, use of framing/ advocating/ illustrating/ inquiring in dialogue, seeking a focus for collaboration, and seeking to bridge incongruities across territories of experience. This felt more spontaneous and more authentic to me, and more resembled Torbert's (1991) term 'stumbling gait' which he uses to characterise the experience at any one time of engaging in more or less incomplete 'experiments-in-practice'. My interventions in the meeting were not pre-planned and smoothly executed, but rather arose in the 'heat of the moment', using the opportunity as it arose to address incongruities across differing domains of experience and to invite others to collaborate in addressing them, thus using the 'energy of the moment'.

- So, what did this 'experiment-in-practice' achieve, and what did I learn? The conflict in the group 'woke me up' in more ways than one. It literally challenged me out of my preoccupation with events outside the meeting to become more present in the meeting. It also alerted me to the realisation that I had to take a much more active role in the group if the marketing was to succeed - I had too easily accommodated to the process which had emerged over time. I could no longer afford to do so.

  The meeting revealed clearly how William finds himself caught between Stewart on the one hand and Jan, myself and the nurses on the other. Although I was stunned at his siding so openly with Stewart, eventually it was he who challenged the process and created the opening I was looking for but could not see a way of achieving myself. I have no way of knowing if the meeting would have progressed differently had I not also intervened at that point. Clearly there was considerable tension 'simmering', which Jan and Luke made explicit. Whether the overt confrontation between Luke and Stewart would have occurred without my framing the need for all views to be respected and a consensus reached, I do not know. I needed to challenge the process in the group but

in a way which moved us on beyond conflict to collaboration, and I needed to become active in the group at this point for my own sense of authenticity. I am interested, in retrospect, how the two doctors accommodated to the change in process. But on the other hand, I feel I had a hand in shifting the focus away from interpersonal disagreement to one of the need to work together for success - this was a frame with which no one could disagree, no matter what their private views were about how this would happen. The increasing levels of participation over the morning vindicated my intuition to intervene at the level of group process and goals rather than at the level of individual members.

- This meeting also 'woke me up' to the idea that I must work more closely with William in making explicit how I work with complex cases. Unless he understands this he will not be able to support what we do. Of the two consultants he is the one with more energy and interest, despite his declared interest in the 'convalescent' option.

- The meeting highlighted interesting patterns of relationship which resonate with the concepts of agency and communion. I saw unmitigated agency as creating a hostile environment for communion in that meeting. The two doctors preference for the 'new niches in the market' were characterised by metaphors of 'forging ahead', 'conquering new fields', 'ownership', having 'high visibility' in the health field, and imposing their views of what was needed on others. These are all characteristics of an agentic strategy, and if unmitigated by characteristics of communion can lead to isolation (of individuals from each other and of the department from other services) , silencing, and unaware damaging or ignorance of contextual patterns which ultimately are important for longer term survival (for example the willingness of other services to collaborate with us).

  By contrast, outside the meetings, the activities of Jan, the nurses and myself were characterised more by communion. Jan had worked hard behind the scenes in facilitating the marketing process, linking the sub-groups together and ensuring they had the resources to do the job. Myself and the nurses had made new links with our existing purchasers and referrers, better understanding their requirements of us, and collaborating more effectively around communicating about referrals, providing more timely and relevant information to them, and acting on their requests as opposed to presuming we knew what they 'needed'. The process of the marketing had allowed us to become more aware of and sensitive to our wider environment, and this in turn had opened up possibilities for more interdependent and mutually respectful working relationships. These activities, and their outcomes, remained muted and unacknowledged in the marketing meetings in the face of the agentic style which held sway and overly-determined the interpersonal process. I felt I needed to exercise considerable agency momentarily in order to allow for more communion to be present in order to redress the balance.

- I feel uncomfortable in presenting Stewart in such a 'dark' way in my writing - although that is how I experienced him in the meeting. I feel the need to note the light side which is there at times, when we join together in friendly and interesting ways that allow us to work together. For example, sharing 'insider' appreciations of drug using culture from our youth, and sharing a scepticism about models of pathology and the degree to which contemporary psychiatry and clinical psychology are based on these, offering false promises about many 'life difficulties'.

Implications of the Marketing.

I will now consider some implications which arose for me from the marketing and which are grounded in my experiences in the meeting as conveyed in the story above.

• 'Complex Cases'

Although this story about the marketing is not about 'complex cases' directly, there was a 'story behind the story'. The marketing process extended discussions with referrers from across the region which inevitably included 'complex cases'. Although we were envisaging a need for a short term rehabilitation service, it became increasingly apparent that there was also a need for the sort of work we were already doing with 'complex cases' which would not fit easily into the more pre-planned concept of short term rehabilitation. So inadvertently, I and the senior nurses developed a more detailed 'map' of the 'patient journey' from the point of referral and learned of referrers' requirements of us in supporting their own work with 'complex cases' as they perceived them to be. As they learned about our work, they became more interested in seeing what we had to offer. The senior nurses on several occasions arranged for referring teams to visit us and would ask me to meet with them and talk about 'complex cases' and how we worked with them. I used Rosemary's story as an exemplar.

In terms of my use of the Hermeneutic Dialectic Process, I had elaborated my 'map' of how 'upstairs' constructed 'complex cases' - the consultants were 'blind' to them, and the rest of us kept the work 'invisible'.

• Finding new markets and new relationships.

As it became clearer that we could, in marketing terms, 'fill this niche in the market', it also became clearer to me that we needed William 'on board' to support the work as clinical director and as consultant psychiatrist. At that time the consultants were still seeing themselves as the 'experts' on what was needed and as having a right by appointment as regional consultants to 'gatekeep' and make decisions about the pattern of service provided to the other districts and about the types of referrals accepted. However, through the marketing the senior nurses and I had received almost unanimous feedback that referrers did not want our service to unilaterally 'gatekeep'. Instead they wished us to accept their judgement about when they were no longer able to meet the needs of their clients as they perceived them to be. They wished for a more collaborative relationship in which they felt their needs had been heard and validated and where the service provided was negotiated.

I did not wish the two consultants to cut across the relationships we had begun to form with the referring teams and undo the gains. As the two consultants were necessary to our service in terms of their medical expertise, and as they 'figure headed' the service as far as the wider environment was concerned, I felt that I had limited options as to how I could work around or through this dilemma. I could work 'around' the consultants, or work 'with' them as I saw it. There were limited degrees of freedom open to me in working around them as we were too tightly bound together as senior members of the department and as members of the Core Group. As such they were part of my immediate reference group for making the service effective. On the other hand, there were limited degrees of freedom open to me in working with them. Their main reference group, albeit it a seemingly unsatisfactory one as they portrayed it, was the consultant's group and the wider world of medicine. I was not part of that world and did not wish to be so. But on balance, I felt I needed to work 'with' them and I felt that I would be more able to do so with William.

Despite public appearances, William was privately interested in the marketing and was beginning to see the importance of understanding 'customer requirements' as an important underpinning for providing a 'quality service'. He had proved the more listening and affirming of the two doctors and the one I most trusted. My past attempts of trying to mediate the effects of the unspoken differences between them was not going to be an effective strategy for supporting the changes I now saw as possible. The marketing meeting had shown me clearly that, in public, the two consultants would always ally with each other. I did not know what passed between them in private, and how much they explored or resolved differences. I could not join their sub-system as doctors, but I could invite William to join my sub-system as practitioners working with 'complex cases'.

If I could develop a closer working relationship with William clinically, and make more 'visible' my work with 'complex cases' in such a way that he could 'see' it, then I believed that the gains would be two-fold. Firstly he could then be more supportive of it, and secondly he might also be able to see in a different way how the department worked 'downstairs' and be a more effective Clinical Director through so doing. I felt it vital for the department that this should be achieved and I saw my making a stronger alliance with William as a potential key. I would be giving up a more neutral position in relation to the two consultants than I had previously adopted, carefully trying to weave between, but this seemed no longer to be an effective strategy.

On another level, I was also interested in developing a relationship with William in which we could value each other's contributions from a position of more in-depth mutual inquiry. I was looking for such a working relationship with a senior male colleague and so my purposes also had a more personal dimension.

• Power.

Curiously enough, at this time I saw power as only a peripheral issue and not as a useful frame for making sense of the patterns of relationship around managing change. Although I saw the consultants as using unilateral power in the meeting in directing the agenda, my analysis was based more on the differences in world views according to profession and gender. I carried this 'bracketing off' of power in relationships into my inquiry with William, and I turn to an account of this next with the consequences of having to re-view my thinking on power.

Developing a collaborative relationship with William.

From this point on I sought to work more closely with William around client/patient care. This seemed to be an 'inquiry niche' which offered most potential for collaboration together. This was a core aspect of both our roles, we had regular contact with each other around casework, and it was in this domain that I wanted him to have a richer appreciation of how I worked. Alternatively, it was a domain in which I believed he could extend his own skills and I wished to support this. I felt that if he could develop this area of his work it would give him a firmer base to work from and enable him to work more collaboratively with other clinicians.

I also wondered if we could together step outside the restraints of professional roles and world views and work together in a way which valued our respective strengths and values. He had an agentic 'crispness' to his approach to clinical work which I valued when feeling slightly muddled or overwhelmed with complexity of cases and periodically sought him out for consultation at such times. I wanted to show him more communal ways of working to complement this so that he could understand and support the 'downstairs' work with the nursing and day care teams. I also saw him as moving too rapidly into challenge and confrontation modes when faced with uncertainty, leaving him feeling isolated from his peers. This was also 'true' with clients/patients as I saw it.

I sought every available opportunity to do this informally at the start of this phase - over coffee, chatting at the top of the stairs outside our office, or when needing to involve him in a particular case. My work with Rosemary had progressed to an interesting phase and I told him stories about this. By now we had acquired additional residential property in preparation for our short term rehabilitation service which provided warden assisted night time accommodation for clients in order that they could attend for day treatments and care. I was offering this to Rosemary at times when she and her family were in crisis and she was requesting admission. She could come in provided she collaborated with us in developing her own care plan. We had discovered that if we supported her in this and did not 'push' treatment for her eating disorder then she increasingly was presenting this to us to work on. A key moment for me was when telling William about this, he burst out laughing and said "It's a 'do nothing' treatment". This captured his imagination and he used this term from then on. In turn he started admitting his own clients in this way. This was the beginning of a more explicit recognition that as a department we offered a service for 'complex cases'. Interestingly, it was mostly women who came to use the residential accommodation and William came to recognise the value in

providing a space for women like Rosemary to review their lives and receive support in exploring new options in the face of complex family problems and social isolation.

This aspect of our relationship became more complex when William began asking me to help him directly with some of his casework by seeing families together with me conducting the interviews. I would discuss with him what his aims for the session were, give him my views about the necessary strategies and process needed to achieve this and then negotiate the roles we would respectively play. I clarified with him that he wished me to conduct the session and 'take charge' of the process. William would happily agree with this but then at the end of the session, after a break in which we would discuss what feedback we would give to the family, he would depart from our agreement and head off on his own tangent. This was usually diametrically opposed to what I felt was needed in order for the family to have a better grasp of dilemmas and difficulties and leave them feeling empowered to deal with them. William would move back into a directive mode by prescribing how they should do things.

On the first occasion this happened, I checked afterwards whether in fact he had not felt in agreement with the way I had conducted the session or with the formulation I had suggested to him. He remarked, "Oh no, I really enjoy the experience of working with someone who is more competent than me. It is not often I feel as though I can sit back and let someone else take charge".

Therefore I persisted with involving him in my work and responding to his invitations to join him in his. I tried different ways of sharing leadership in sessions - he leading with me observing, us sharing leadership conjointly, me leading with him observing. I could find no comfortable way in which I felt both styles could be harnessed in the best interests of the client without resorting to a more explicit supervisor/supervisee relationship. I was reluctant to do this yet.

So I suggested we support our work together by having weekly peer review meetings, thinking that if we had more time to reflect at leisure about our work we could address some higher order assumptions which could facilitate this working arrangement. But although he agreed we did not get to the point of regularly having them. He often had more pressing demands and seemed tentative when I questioned it. For my part I was not wishing to intrude too far, so together we allowed this to fall by the wayside. It was clear he preferred the implicit and the informal.

My beginning assumptions had been that I could offer an alternative set of frames for working with clients through coaching, modelling and dialogue. I did not believe that the formal supervisor/supervisee relationship was the only context for learning new skills - although it is an extremely important one, and one in which I have experienced much learning from both positions. So I was happy to proceed with an informal arrangement for the time being.

Yet I came to realise that this seeming preference for the informal learning arrangement we had together was in contradiction to a set of beliefs William held about the world of work. He

looked for certainty, needed to see large changes occurring in the short term, and liked frameworks in which rules and hierarchical lines of authority were clear. He also expected a clear demonstration from clients of commitment to change This set of understandings emerged over time from conversations together where these issues were both explicitly and implicitly discussed. He once said "I am not a therapist, I do not have the skills. I am a doctor and a researcher."

I was unwilling to invite a relationship of supervisor and supervisee with its explicit hierarchy of expertise, partly because I did not think he would accept it and partly because of my own needs. For my part, I was partially aware of some of my own life scripts operating. I recognised a need to find a 'brotherly relationship' with another man and I sought this with William. We shared many life stories together and I came to know him more intimately. But correspondingly, I am not someone who takes risks with intimacy and when I sense vulnerability in others, particularly men, I tend to wait at a respectful distance, offering support but not challenge. In our discussions together, William took risks in allowing himself to show his vulnerability. I maintained a respectful distance, offering occasional gentle challenges, but usually 'backing off' and allowing what I saw as a 'saving of face'. I did not take risks by pursuing further inquiry or challenging some of the implicit assumptions I saw as lying behind the vulnerability. I found myself always trying to find a position in the relationship in which we maintained an equality of status as individuals independent of professional roles. I found myself always seeking a position which avoided William being 'one down'. In doing so I was often muting myself in relation to him to preserve the quality of equal valuing I was seeking. I was aware that I did this for both of us, but it took some time before I understood in more depth what unexamined assumptions I was carrying in the form of life scripts which informed this.

There were times when this arrangement gave rise to frustration on my part, mostly with myself. I would encourage him to take the lead in casework situations which then turned out badly from my point of view and I would be angry with myself for doing this, knowing the risk from the start and knowing that I expected much from him that he probably was not aware of. The times I became frustrated with William was when he behaved in an un-inquiring and 'shoot from the hip' style with colleagues outside the department. This would either put his own reputation at risk, or limit the extent to which others would be prepared to 'do business' with us. He would become either very wounded or dismissive on getting feedback that he was seen this way. If I inquired into this with him we would slip into our familiar pattern of him becoming increasingly vexed or wounded and me backing off.

On one occasion when he was feeling particularly vexed at his medical colleagues across the Trust I listened, inquired into his beliefs about what was happening, then asked him to consider some alternative explanations. He replied "But David, you are so psychologically healthy". This was not offered in an ironic tone, but it effectively silenced me as I heard the sub-text 'I cannot see the world your way so please do not pursue this'.

It was only when our department was required to work more collaboratively with other services external to the trust and with other departments within the Trust that this relationship began to change. It was in the context of working with William and others in developing an Intensive Care Unit for acutely distressed people that I discovered more about myself, my relationships with other men and power

Developing an Intensive Care Unit

I was very aware of how William was perceived by many of his colleagues from all disciplines - as sometimes arrogant, cavalier in his disregard for other's opinions, somewhat impulsive, and as challenging of their views when he disagreed. By some he was seen as ambitious, and hence were in competition with him for senior posts. By others he was seen as an enthusiastic supporter of the health 'reforms' and hence not to be trusted. Not all saw him this way, and a few nurses who had worked more closely with him in clinical situations when he was a senior registrar valued him for always 'being there when there was trouble'.

Although I could see their perspective, I also felt that I had another view of him from working closely with him and always offered that to people if asked about my relationship with him. I wished them to be able to see his strengths (his humour and concern for others which lay behind the public persona) and to appreciate how much he was prepared to take risks in allowing others autonomy if he understood what they were doing. I was unaware of the extent to which I was seen as a 'stabilising influence' until a pivotal meeting about the development of a new service within the Trust.

By this time we had our marketing strategy underway. Short term rehabilitation and a service for 'complex cases' were now earning us substantial new income. However, we were still struggling to cover our costs each year and William was still keen on the department solving this by providing some sort of service to private patients. He was reluctant to find a solution which relied on any closer relationship with other departments in the Trust.

At this stage, Jan had just left the department to take up an executive director's position on the Trust. She had been working with nurses across the Trust for several years to develop a proposal for a nursing led Intensive Care Unit which would provide a service to all departments. This proposal had been accepted by the Trust Executive and now it was a matter of finding a 'home' for it within a department which could provide the managerial and administrative structures as well as a multi-disciplinary support. The Trust Executive group (now including Jan) offered us this role. In so doing it sought to solve two problems - our financial short-fall, and the impasse it was experiencing with the large Adult Mental Health Department which insisted it was the logical home but which could never take the necessary organisational steps to implement it.

William was very apprehensive because he doubted the degree of support he would receive from the other doctors in the Trust. He expected to be undermined by them. As Stewart was not interested himself in expanding his clinical role, and was only reluctantly accepting of the

need for our department to take this step, William felt he was going to be on his own as a doctor. On the other hand it offered a career step for him and it solved an anxiety-provoking financial burden. After much discussion between our Core Group and the Executive Group we agreed in principle to take it on. A large meeting was organised on Christmas Eve of senior members of all departments to discuss the proposal and see if there was sufficient agreement. The Chief Executive felt he was undertaking something of a gamble in making this proposal and needed to see what degree of support it would gain before making a final decision.

I attended the meeting with a clear strategy in mind. I saw many opportunities in this proposal to 'unlock many log-jams' across the Trust with regard to how acutely disturbed patients were cared for, and with regard to opening up communication between departments. I had prior knowledge that several consultants in adult mental health would see this proposal as 'stealing their territory' and would overtly or covertly oppose it. I needed to speak strongly from a position of confidence that we could do the job, but also strongly from a position of offering collaboration and support rather than competition.

In the meeting all had an opportunity to speak. There was a growing agreement for the proposal until it came to the doctors to speak. The lead consultant from the Adult Mental Health Department openly confronted William - "We do not think you have the skills to do the job". We were all momentarily stunned, we had never seen consultants break ranks in public like this before. However, William held his own and the meeting ended with the doctors agreeing to continue meeting to sort out how they could work together.

The executive group decided to go ahead with the venture. I learned later that my speaking in the meeting had increased the confidence of the Chief Executive that we could develop the service. He saw me as an "expert case manager" and felt that my involvement would stabilise and support William.

Confrontation.

Following this time, my relationship with William deteriorated. Jan's leaving the department had left a big hole for many people. William no longer had someone to support him managerially and although I was willing to work more closely with him to help him make the transition, this proved to be impossible. He began isolating himself, became inconsistent and increasingly made unilateral decisions without consultation. I became worried for him and worked harder to try to help but could not 'get it right' for him. I understood that he might have felt abandoned by Jan, that he was feeling wounded by his medical colleagues and sought to overlook the frustrations of trying to work with him. I tried to hold things together when his decisions caused chaos and confusion. I became miserable and unhappy, then increasingly angry as I saw all the things the department had worked hard for at risk of slipping away. I sat on this for a while until 'one event too far'. He had made a decision involving me but without consultation or consideration for my feelings. I was insulted. I had to say something to him before a

department meeting in which the particular issue would arise, but could not get to meet him so I wrote a long letter. I was concerned for him, I cared about him, and I regretted very much having to write rather than say this face to face, but I was very angry and wanted him to understand clearly the consequences of his management style which I saw as alienating of myself and others. I could only support him and work with him if he was prepared to be more open and collaborative.

William responded immediately. He caught me before an early morning meeting the next day, asking to talk. I did not wish to miss the meeting but he was clearly very distressed and I deferred. I do not wish to reveal the content of our meeting but the significance for me was that it was the beginning of me breaking the previous pattern I had seen as operating between us. I did nothing to soften the confrontation, although I did this with care. He offered to stand down as Clinical Director and for me to take his place. I refused as I saw this as constructing the situation as an 'either/or' struggle for control over territory. I did not see it this way. I replied by saying "I do not wish the job. But if I thought you genuinely believed I would be the better director, then I would consider it. I think you should sleep on that one for a while then let me know". This was never mentioned again.

Our relationship became more open for a while and so I risked disagreeing with him more openly, which on one occasion led to an argument in which we both lost our tempers and swore at each other. I felt then that he was not going to let me work more closely with him and it was clear that I could not replace the role Jan had played in supporting him. For many months our relationship became more distant again as William retreated into isolation.

Towards a realisation about power and vulnerability.

Over the course of the next year I took the lead in working with clinical teams from across the whole Trust in developing a consensus about the 'Patient Journey' from the point of referral through the ICU and back to the referring team again. This was in preparation for the opening of the service and was both challenging and productive. In that context William and I could work together, although he was very apprehensive about being challenged by consultant colleagues. After one meeting, a senior nurse from the acute psychiatry department commented that she had never sat in a multidisciplinary meeting which had been so open and such fun.

Another commented on my seeming hesitancy in opening another meeting in which I anticipated much difference of agreement and potential conflict. He said "you are a powerful person, why were you so tentative in opening the meeting." On inquiry he was referring to my inviting possible disagreement after framing the purpose of the meeting and the objectives we needed to reach, allowing a long enough pause for reply. I knew that there were different positions held by members of the meeting on the existence and the nature of the ICU, and I wished to test out whether they would be voiced and to create a space at the outset for that to happen. I wished to avoid the possibility that they would be voiced outside the meeting and

thus lead to less robust decisions. I explained this to him, but he remained mystified as to why I needed to do that. He saw it that I had enough "power to take people with you confidently". I in my turn did not see the issue in terms of power.

While this was happening, we were gradually losing direction within the department. In Jan's absence, Ann the ward manager had taken up a part time role as business manager and Gerry the senior clinical nurse had taken over the nursing lead. They both became members of the core group but were struggling in their new roles and did not have the confidence of the staff groups they were meant to be leading. Furthermore, the process within the core group left them feeling mystified and silenced. The process I described in the marketing meeting came to the fore again. I spent much time with both Ann and Gerry discussing our respective views of the processes operating in the department, hoping I could 'help them up to speed' in their new roles. However, this proved to be slow work, and neither seemed to be developing the confidence or skills which were required. I also spent time with William and Stewart, trying to support them in dealing with the problems which cropped up in the day to day services for which they had responsibility.

Although Stewart had agreed with the department taking on the ICU, he now thought it was a bad idea as it became clear about how much time it would take from senior staff to support it. William, who was continually anxious about the degree of cooperation he would get from other doctors, swung wildly from one extreme to another and in the face of Stewart's pessimism he himself became pessimistic. Within the core group meetings he joined with Stewart by engaging in negative and blaming dialogue about the way other departments were run and about the way the Trust was managed. Although I understood by now that this was William's way of dealing with the unacknowledged conflict between the two over control of the resources within the department, and as a reflection of his anxiety about his relationship with consultants in other departments, I nonetheless felt this as unproductive and silencing of others. By joining together in blaming 'outsiders' the two consultants seemed to be preserving the status quo.

Stewart was finding the drugs work tedious and overwhelming and was looking for ways of moving more resources from within the department into this area. This caused conflict among staff at many levels. Although William privately disagreed with Stewart's strategy, he would not confront the issue openly and explicitly as clinical director. He felt restrained by the assumptions within their shared professional world that no one consultant could tell another what to do, and restrained by his own assumptions about his role as clinical director that he needed formal authority from the Chief Executive to do so. The fact that the Chief Executive was also a part-time consultant rendered this as unlikely in William's view. Therefore he saw himself as being without authority to challenge openly the way in which Stewart organised his work and in which he covertly used a disproportionate amount of limited resources.

I alternated between two extremes. On the one hand trying to hold the core group together by supporting individuals outside the weekly meetings, on the other 'sitting back and letting it happen' within the meetings, feeling impotent to do anything effective. I became increasingly 'swamped', feeling as though I was losing my identity within the department and as though I was forever doing 'damage limitation'. It seemed that the more I moved forward in developing the ICU work, the more unstable things became in the department. I felt caught between the two extremes.

I also felt strongly that I was wasting my time being in the core group, that I should withdraw from it and get on with my own work. It seemed clear that the only rational alternative to the current chaos was to work with like-minded people in developing the ICU and to redraw the boundaries around clear psychological treatment roles within the department and work with people who were interested. I needed to take charge of my area of responsibility and put a boundary around that so that I could protect myself and the other psychologist from the chaos. My style of seeking to support communion had lead me into feeling flooded and overwhelmed and 'out of control'.

But equally strongly, I felt a reluctance which gave rise to many questions. What was my 'own work' within the department? I had repeatedly declined to 'take control of psychological treatments' in an agentic and high profile way. What was it that I could now retreat to given that my purpose had been to diffuse 'psychological treatments' into the fabric of the department and not make it a discrete entity? If I decided to put a boundary around 'psychological treatments' where would this be? But most importantly why had I not done this before? If I had, I would not now be in the situation of feeling that all I had worked for was in a precarious position. Although I could understand that the department was going through a process of adaptation and change in taking on yet another venture which required a re-negotiation of relationships, that explanation alone did not help.

Although the frame of gender and agency and communion partially helped me understand these dilemmas, although I could see the need for exercising more agency to protect the modality of communion in my work, and although I could see a strategy for doing so, I could not understand my reluctance. I wrote at length about the dilemmas but could not find a way through. I felt in an emotional turmoil and discussions with Jan about this often led to conflict She would highlight or point out alternatives with which I could rationally agree but to which emotionally I felt enormous resistance and to which I would reply "yes, but...". As I wrote further in my reflective diaries, I realised that the theme of power and powerlessness connected all my feelings and frustrations. I realised that I needed to confront this. I had been ignoring power as a 'reality' and it was now presenting itself to me in a way I could not ignore. In the following chapter I explore the literature on power and find some conceptions which fit with my values. I also discover some 'life scripts' which have been implicitly informing my relations with power and men. These discoveries allow me to 'move on'.

14. RE-CONCEPTUALISING POWER AND DISCOVERING RESTRAINING 'LIFE SCRIPTS'.

Introduction.

In this chapter I reflect on power as a dimension to my dilemmas within the core group, then turn to the literature on power to find some answers. I gain a new perspective on power and the various ways in which this is exercised in relationships and feel more comfortable in seeing myself as exercising certain types of power. However, this does not fully resolve my dilemmas and I find a way forward by looking back into the past, discovering how certain 'life scripts' exert a restraining influence in relation to power, vulnerability and other men. The recognition of these life scripts and how they were operating for me in my work relationships enabled me to find a way of 'moving on' in pursuing more congruently than before what I believed to be important directions for the services and for my roles in them.

Power and powerlessness.

In thinking about power and my relationships with the two consultants in the setting of the Core Group, I realised that I had chosen (almost unawarely) to see myself as operating outside the concept of power and its effects within relationships. In wondering why this was so and in reflecting at length about it, I became aware that I had implicitly seen the two consultants as exercising forms of power which amounted to 'power over'. This had especially been the case when change was in the offing which challenged their position as 'experts' or as autonomous agents.

I had come to understand that their position as consultants contained an inherent contradiction which afforded them power while at the same time rendering them vulnerable. Their vulnerability lay in their dependence on other professionals to carry out the 'treatments' which they 'prescribed'. The skills and abilities of the various professionals frequently exceeded those of the doctors in these areas. Doctors offset this by forging a role for themselves as 'gatekeepers' to the service, maintaining a sovereignty over this role by 'knowing best what works' and by delegating tasks to other professionals according to their 'diagnosis' of what was required. The professional socialisation of many 'professions allied to medicine' contained implicitly or explicitly a recognition of this 'right' or claim by doctors to superior knowledge and so individuals seldom challenge this arrangement overtly. Clinical psychology claims to have developed a body of knowledge which enables its practitioners to practice independently of doctors, but this creates a world of competition with doctors which can be equally disabling of collaborative forms of inquiry.

In my relationships with the two consultants, and with William in particular, I was seeking to avoid competition and seeking instead to find ways of fostering mutual inquiry from a position of mutual recognition and respect. Similarly, although the marketing meeting had thrown up issues of power in the face of imminent change, I had chosen to work outside an explicit

understanding or acknowledgement of power issues. In that meeting I had seen the two consultants use 'power over' and I sought to bypass this in my relationship with them. I had sought to inquire on the 'vulnerable' side of the contradiction, to support William in gaining confidence in his therapeutic skills and to foster trust and collaboration in place of competition. I was both intellectually and experientially prepared to allow myself to be vulnerable in order to meet them at that 'place', but I had not expected to end up feeling so helpless, frustrated, despondent and 'powerless'. It was my lived experience of feeling powerless in relation to the two consultants 'resistance' to change that alerted me to the possibility that I had underestimated power as an issue and that I had perhaps under conceptualised it. I had been operating as if the only form of power was 'power over' and I now found myself in the ironical position of feeling 'power-less' by virtue of bracketing it off and operating outside any explicit moment to moment understanding of power.

Although I had Torbert's (1991) analysis of power to draw on to aid in making sense of my experience of powerlessness, I did not consider it as offering a way through. Some possible reasons why this was so became clearer later and I will reflect on these as I consider alternative conceptions of power. I needed to find if there were forms which fitted my valuing of mutuality and non-controlling interdependency. I first of all turned to literature on power and gender.

Power, gender and knowledge.

In turning to the wider literature on power I became immediately aware of the multiplicity of definitions and of the different ways it was seen as either linked to or inseparable from issues of gender and knowledge. This reading and my making sense of it is continuing and ever changing, but for the purposes of this thesis I wish only to give a summary understanding from that time. For this reason I will skip lightly over large areas in order to lead to the personal position I arrived at for the purposes of resolving my dilemmas within my relationships at work.

Some writers see power as a separate entity, characteristic or attribute which individuals or social groups possess with which to influence outcomes in the field of human affairs. Others, writing explicitly from a post-modern perspective, see power as inseparable from gender, knowledge and 'subjectivity'. The latter come mostly from within a critical sociology and largely share the view that power and gender are inherent in social structures and relationships. In other words, power and gender are social products, constituted and lived through language and other social practices, and experienced differently according to place in history, class, sex, race/culture and so on. (e.g. Radtke and Stam 1994). Within this view there is no one universal experience of power or gender.

This latter view of power and gender sees the more traditional views (defined as characteristics or attributes possessed by persons) as essentialist, reflecting a foundational reality or essence outside our social construction of 'it'. Much writing on power in this post-modern vein draws upon the work of Foucault on power and knowledge. Foucault (1980) maintains that power

and knowledge directly imply each other. There is no power relation independent of some body of knowledge, nor is there a body of knowledge which does not presuppose and constitute at the same time a set of power relations. Furthermore, he sees power in relational terms, as not only the possession of individuals but as a process occurring between individuals within relationships.

> *"Power must be analysed as something which circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate through its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target; they are always also the elements of its articulation. In other words, individuals are the vehicles of power, not its points of application." (p98) (cited in Radtke and Stam, ibid, p4)*

While some feminists argue that this approach is blind to the experiences of women, others have used it to theorise about gender relations. Kerfoot and Knights (1994) are such an example. They wish to depart from a 'power-over' view implicit in much theorising about women's unequal social position. This view of power as the property of some to the exclusion of others, and beyond the individual, "sets up a dichotomous relationship between the individual and the social world, between powerful men and powerless women as largely internally undifferentiated categories, and imputes passivity to all women." (p70)

They see Foucault's alternative theorisation of power as providing a point of departure. Power in his conceptualisation exists only in its exercise and operates through the production of particular knowledges - around discourses of gender and sexuality, pleasure and morality, sanity and madness, and the law as examples. Within this view, power is in reciprocal relationship to subjectivity, where subjectivity can be defined as "individual self-consciousness inscribed in particular ideals of behaviour surrounding categories of persons, objects, practises or institutions. Subjectivity is constituted through the exercise of power within which conceptions of personal identity, gender and sexuality come to be generated." (p70). From here they view individuals as capable of actively positioning themselves within, or of finding their own location amongst, competing discourses, rather than only being passively positioned by them. Therefore they see gendered subjectivities as fractured, historically shifting, constantly unstable, and potentially multiple.

(Methodologically speaking, this leads them to advocate an examination of local practices and conditions because they will contain and reflect wider power relations, and will be more easily amenable to empirical investigation.)

Implications of an alternative perspective on power.

This view was interesting to me on several counts. Firstly, it occurred to me that my implicit constructing of the consultants as capable of exercising 'power-over' in the face of change positioned me as potentially 'power-less' in relation to them. This was particularly true in my relationship with William where I had not conceptualised the power aspects of relationship I attempted to develop in alternative ways. This failure had rendered me susceptible to becoming 'power-less'.

Secondly, there must be multiple forms of power available to exercise within the concept of subjectivity as being historically shifting, continually unstable, potentially multiple and gendered. If so, then this may help me identify alternative forms of power, so that I am not positioned and do not position myself as being only within 'power-over' relationships. I needed to identify these.

Thirdly, I considered the implications of moving away from seeing the consultants as possessing power in relation to my not-possessing power, towards seeing us as transacting with each other within a wider set of social practices which were constituted and defined by discourses around what forms of knowledge were publicly privileged within mental health services. This gave rise to the question 'how do individuals and groups 'position' themselves differently among alternative discourses without explicit dialogue, without collaborative inquiry?' I had attempted such a venture and had become 'stuck'. Was this because we had not been able to achieve collaborative inquiry? If so, was that because we were being 'positioned' by discourses about what constituted acceptable forms of relationships and admissible knowledge both as men and as mental health professionals (doctors and psychologists). Did these discourses exclude differing forms of being men and professionals, silencing and submerging the experiences of being vulnerable, open to others and 'not knowing'. Clearly yes - my own experiences earlier in the research were testament to this. So how could I continue to relate to these men who perhaps had not made that particular journey, without being excluded by their continued reliance on mystery-mastery strategies in the face of uncertainty, vulnerability and change?

Fourthly, within this analysis, I began to see how my reading of Torbert's (1991) conceptualisation of power had not helped me out of this position. Rawl's theory of justice upon which he based his transformative power of balance contained many unexamined assumptions. It was based on the notion of a society modelled on the family in which the parents coached the children in their development of a moral and ethical world view. There was no mention by Torbert about the assumptions behind 'family' and 'moral development'. Connell (1994) criticises classical theories of the state and models of liberal power as being gender-blind and hence likely to reflect patriarchal world views. Citizens are unsexed in such theories and are abstracted from social context. He cites Pateman (1988) who argues that the fraternal 'social contract' of Rousseau and later liberalism is based on an implicit sexual

contract requiring the subordination of women. He also cites Kearn (1984) who specifically critiques Rawl's theory of justice as embodying a social contract implicitly between men, presumed to be heads of families and in charge of wives and children (and therefore, according to my developing understanding, a patriarchal arrangement which does not admit of women's experience nor of alternative forms of power and masculinity for men).

Theories of moral development have also been challenged as being gender-blind. For example, Gilligan (1982) and Belenky et al (1986) have contested mainstream theories as excluding the voices of women. Their own works have shown that women tend to make moral decisions and think about themselves and the world in terms different to those of men. Gilligan found that women tended to make moral decisions based on notions of responsibility and care for the actual others involved in their lives, whereas men tended to appeal to notions of rights based on abstract and generalised theories of justice. Belenky et al found that women's epistemologies and catalysts for development were by and large different from those found among studies on male development, although they themselves studied only women. The extent to which these 'different ways of knowing' are gendered and sex-linked is still a matter for debate.

It is not clear from Torbert's work the extent to which the theories of development upon which he based his developmental model of leadership address the implications of gender difference. In my reading of his work the presence of the communion tradition remain implicit and muted and so I saw his strategies for action inquiry more aligned with the agentic. I will return to Torbert's model of power later in this chapter.

I next turned to contemporary 'men's studies' to look for answers to my questions. Perhaps this emerging domain of work could provide me with non-oppressive forms of power which would serve the interests of both the masculine and the feminine, and agency and communion, as I attempted to live them. I found little of direct relevance to forms of power. Much of this area is again within a critical sociological tradition and left me wondering how I could affect change at the level of individual experience.

Bach (1993) critiques men's studies and observes that much of the literature falls into either of two camps. On the one hand, there is sociological analysis which seeks to understand how dominant forms of masculinity are produced and institutionalised through a variety of social practices and discourses. Such institutionalised standpoints legitimise and privilege certain experiences, knowledge and practises over others. These standpoints, according to this analysis, exclude and dominate women and those men whose masculinities do not conform to the institutionalised standards.

On the other hand, there is a type of analysis, including both sociological (e.g. Connell, 1987) and more 'popular' individual/psychological (e.g. Keen, 1992) which seeks to uncover alternative forms of masculinity through inquiry into men's lived experience. Within this analysis, self-transformation occurs through men taking up alternative standpoints on

masculinity which organise their experience and which provide non-oppressive forms of being and living. Bach identifies a dilemma between the two types of analysis. The individual is either 'overly determined' and without choice, or alternatively is 'unfettered' in a choice of alternative 'selves'. Neither alone are justifiable as a basis for transformation.

Bach maps out an inter-subjective theory of self which transcends these two polarities, interesting to me in itself and an area I am still pondering upon, but not germane to my immediate purpose. I note it here because it articulated some of my unease at the popular men's studies literature I alluded to earlier in looking for an analysis of gender.

French (1994) sees power as being conceptualised as either 'power over' (dominance) or 'power to' (ability). It was the latter I was seeking to understand more and it was in the organisational literature where I found two sources which more readily met my needs.

Power in organisations - individual and relational.

Power and conflicts of interest.

The first source I will take from is that of Morgan (1986). He takes a pluralistic look at organisations, considering the construct of organisation as a set of images which offer a range of perspectives or vantage points according to whichever 'image' is used. One of the images or metaphors which he uses to examine organisations is that of 'organisation as government', seeing it as offering a means of unravelling the politics of day-to-day life within . He suggests that the term 'political' in its original conception stemmed from the view that where interests are divergent, society should provide a means of allowing individuals to reconcile their differences through consultation and negotiation, as in Aristotle's use of the term. Morgan therefore adopts the term 'political' to acknowledge the interplay of competing interests which occurs in an organisation, and the term 'government' to acknowledge that attempts are made to create order and direction among these competing interests. By using these perspectives he believes that important qualities of organisation can be grasped which are often overlooked or ignored.

It is within the political metaphor that Morgan addresses the issue of power. He adopts the view that "Power is the medium through which conflicts of interest are ultimately resolved. Power influences who gets what, when, and how." (p158). He acknowledges the problematic nature of the concept of power with its many definitions, ranging from an entity or characteristic someone possesses, to a property of a social relationship where individuals are carriers and express some more fundamental and deep structures within our social organisation. His essential basis for understanding power is that it has a great deal to do with asymmetrical patterns of dependence whereby one person or group becomes dependent on another in an unbalanced way, and also to do with an ability to define realities in such a way as to lead others to perceive and enact relations in a particular way.

Morgan draws on a range of different conceptions of power in order to create an analytical framework to help understand and identify the ways in which organisational members can exert

their influence. He lists a series of 'sources' of power which he sees as a useful set of tools with which to decode dynamics of organisational life. He sees this list as incomplete, but nonetheless giving individuals a choice, if they so wish, to orient themselves in a politicised way. My interest in this list of 'sources' of power was that it made available to me descriptions of power and power relationships which met my experience, which mapped onto my developing analysis of power, and which potentially served my understandings of agency and communion.

I will summarise a description of each item in Morgan's list, then afterwards comment further on their implications for me. I note here that within each of his descriptions there are dimensions of both 'power over' and 'power to'. In most, he makes these explicit, and where he does not make explicit the facilitative or 'power to' dimension I will add my own speculations in brackets.

Morgan's (1986) list of 'sources' of power is as follows.

- *Formal Authority.* A form of legitimised power that is respected and acknowledged by those with whom one interacts. It can arise through personal charisma, tradition, or the rule of law. Most typically in organisations this form of power is bureaucratic and is afforded through the position one holds with its associated rights and obligations.
- *Control of scarce resources.* Resources include money, materials, personnel, skills, access to technology, and access to support from customers and the wider community. Scarcity and dependence are the keys to the exercise of this type of power. [Correspondingly, I see the sharing of scarce resources and the fostering of mutually enhancing interdependence as a facilitative form of exercising power]
- *Use of organisational structures, rules, and regulations.* These can be viewed as either aids to task performance, or alternatively as products and reflections of a struggle for political control. Structures, rules and regulations can be seen as defining contested terrains which are forever being negotiated, preserved or changed.
- *Control of decision processes.* Morgan sees three elements of decision making as being: decision *premises* in the form of vocabularies, structures of communication, attitudes, beliefs, rules and procedures; decision *processes*, referring to the 'how, when, where and with who' of decision making; and decision *issues and objectives,* referring to the various constraints, alternatives, values and outcomes.
  Power or control can be exercised by the extent to which individuals or groups can shape these three elements, some of which are more invisible or implicit than others.
  [I see that a facilitative power can be exercised by inquiring into these elements and holding them up explicitly for examination and negotiation].
- *Control of knowledge and information.* The structuring of attention to issues which define 'realities' for decision making by controlling the availability of knowledge and information. Can also be use of 'expert' knowledge to weave patterns of dependency.
  [Alternatively, in my view, 'expert' knowledge can be used to weave patterns of mutually enhancing inter-dependence and relative autonomy.]

- *Control of boundaries.* Boundary here is used to refer to the interface between different elements of an organisation. By monitoring and controlling boundary transactions, an individual can monitor developments within and without the organisation and initiate timely interventions, and can interpret what is happening and influence the definition of organisational realities. Such boundary management can be used to either integrate or isolate.
- *Ability to cope with uncertainty.* An ability to deal with unpredictable or discontinuous situations which have considerable implications for all or part of the organisation. These can be environmental or operational. Power or influence is afforded by the degree to which the individual/s have requisite skills and are central to the operations. Such power can be preserved by ensuring uncertainties continue.
- *Control of technology.* This can be overt or covert, facilitative or obstructive.
- *Interpersonal alliances, networks, and control of 'informal organisations'* Built around an identity of interests or mutually beneficial exchange. Membership of interlocking informal networks allow the exercise of interpersonal influence which can shape attitudes and values. The building of these can incorporate both 'friends' as well as 'enemies' in the interests of reaching beyond immediate issues to build for the future. These processes can remain highly informal and to a degree, invisible. They can also be institutionalised, such as through professional associations, or can be "power behind the throne" arrangements.
- *Control of counterorganisations.* The exercise of a countervailing power when one is not part of the 'establishment', through formation of alternatives such as: trades unions, consumers associations, lobby groups and so on.

  [In my experience in health care, the inclusion of service users groups in the defining and setting of quality standards can have the effect of providing alternative frames to the 'insider' views of the professionals.]
- *symbolism and the management of meaning.* The shaping or defining of realities so that members act in ways which further the individual's or the organisation's interests. Authoritarian leaders impose, whereas democratic leaders derive through careful listening and dialogue. This form of power can be exercised through use of imagery, theatre, language, symbols, stories, ceremonies, rituals. Use of gamesmanship is recognised, where individuals may use high profile "brawling" or subtle "fox-like" tactics to shape key impressions.
- *Gender and the management of gender relations.* Includes both the open forms of discrimination and harassment as well as the less visible assumptions underlying the culture of an organisation which privilege male values at the exclusion of the female. The individual is inevitably part of a set of power relations which shape and are shaped by gender realities, and hence must find a strategy for countermanding them. The gender biases are to be seen in the language, rituals, myths, stories and other modes of symbolism shaping the organisation's culture.

- *Structural factors that define the stage of action.* This dimension is founded on the view that people are agents or carriers of power relations embedded in the wider structure of society. Thus whichever form of power an individual or group exercises, it can only do so to the extent it is meaningful in a wider ecology. For example, the factory worker's power to slow production is ultimately sourced by the structure of productive activity which underpins the organisation and society. This view requires an historical perspective which understands the logic of change shaping the social epoch in which people are living. It is this multiple structuring of experience which gives rise to pluralist forms of power.

  [This conceptualisation allows for multiple framings of events and hence greater 'degrees of freedom' about how one can participate in order to achieve transformative relationships.]
- *The power one already has.* This is based on the principle that "power is a route to power" and Morgan sees it as having three forms: an 'investment' metaphor in which a favour given can be drawn upon at a later date; a 'honey-pot' metaphor in which the presence of power attracts and sustains people who wish to feed off that power, and in so doing further the power of the holder; and an 'empowering' metaphor in the form of 'success breeds success', where a positive feedback loop can be created when an individual experiences progress or success and is energised to achieve further. Morgan sees this latter form as a transformative power.

Morgan's theorising about power (as opposed to his descriptions) is more implicit than explicit and I had several problems with his descriptions which I will briefly describe and attempt to resolve. A systemic perspective does not view any one element of a system as having 'control over' any other element as the elements are linked to each other by patterns of mutual interaction and interdependence. The use of the word 'control' by Morgan connotes a linear causality. However, at the level of individual experience I allow that I can feel 'controlled' at any one moment. The word 'influence' would better allow for the notion of circular causality embodied in a systems perspective. Any use of the word 'control' would be best prefixed with an imagined 'as if'. Similarly, the language Morgan uses sometimes connotes power as an essence to be wielded unilaterally. However, I borrow from Foucault to imagine these form of power as both exercised by and exercising of individuals and groups.

Finally, I see that some of these sources of power can either be used to create hierarchies of influence, or alternatively non-hierarchical and mutually enhancing interdependencies - perhaps both/and according to the constructor/s and their purposes.

My second source came from Marshall (1984) and she is more purposeful about making explicit the underlying value system by which she clusters various sources of power together.

Power which serves agency and communion.

Marshall (1984) draws upon a pool of sources to develop a mutli-dimensional model of power which serves her theorising on gender, agency and communion in offering alternatives for women managers in organisations. She seeks to move away from conceptions of power which are competitive, a matter of individual ownership, motivated toward control and expressed through doing. Instead she seeks conceptions which are communion based and which "can be cooperative, based in joint ownership, directed towards influence and expressed in individual's quality of being" (p.108). The theme of power was 'fine print' to me in my earlier readings of agency and communion, and at this point became 'bold print' when I considered my above discomforts with Morgan's (1986) list of 'sources' of power.

Marshall's model has four dimensions which map onto characteristics of both traditions of agency and communion. While there are similarities between some of her factors and those of Morgan's, Marshall is more explicit in how she groups them. These four dimensions of power are as follows:

- *Over others.* This dimension relies on traditional notion of power as a personal resource with which to influence decision-making in one's own interests. It informs relationships which are essentially asymmetrical. It includes: coercion; reward; ability to access organisational rewards and punishments for others; power arising from formal position and legitimate authority; expert knowledge; personal charisma.
- *Structural factors.* In this dimension the individual's power arises from their position in the organisation, where the value placed on this form of power is dependent on the wider values within the organisation. It includes: centrality to organisational tasks; handling uncertainty and risk; relative numbers within group membership; visibility; and power through providing new perspectives.
- *Through/with others.* This dimension reflects power as arising by and through relationships which are essentially symmetrical. It includes: informal networks; politics; coaching/mentor relationships; and being attentive to wider community issues.
- *Personal power.* A dimension which addresses individual aspects of power which reflect a range of bases of independence of being and doing. It includes: competence; wholeness; self-esteem; autonomy; definitional sensitivity and capability; stamina and resilience; change and regeneration.

Unlike Morgan, Marshall seeks to make explicit her views on power as relational, even though traditional views such as the 'over others' dimension encourages spurious notions of independence. Furthermore, she seeks forms of power in which symmetry is achievable in relationships and avoids assigning credits, such as in her third 'through/with others' dimension. Her fourth 'personal' dimension is intended to further the notion of self-esteem as being grounded in self-validation rather than in ease in public relationships.

Re-positioning myself in the concept of 'power'.

I do not wish to look at each potential source of power in detail and consider the degree to which they were available to me within my network of work relationships. What was important to me was that I recognised them all as being present in my setting and myself as having participated in and as exercising many of them. This recognition had the effect of positioning me well outside the 'power over' relationship with doctors. It was possible to see this aspect as being present, but as being alongside many other sources and forms. I had access to many and it shifted my view of being powerless in the face of the doctors reluctance to collaborate in making those changes which would bring us in closer relationship with other departments and agencies. I felt I had some 'flesh on the bones' of power as a set of concepts which allowed me to see possibilities for disengaging from the current patterns of relationship within the core group. I had a richer conceptualisation of power which mapped onto my experience and which fitted with my developing set of theoretical frameworks and values.

Having said this, there were several other implications which arose for me in considering this array of sources and forms. Firstly I could see that at times I may have vacated legitimate authority by not taking charge of psychological treatments in an agentic fashion, which may have confused others who were initially requiring clear and unambiguous directions. This effect for them may not have been facilitating of growth and change. In speculating on the nature of power, Morgan (1986) sees it as having a "great deal to do with asymmetrical patterns of dependence whereby an individual or unit becomes dependent on another in an unbalanced way" (p185). It was exactly this conception of power with which I was most uncomfortable and I sought at all times to avoid "unbalanced" dependency in relationships. I saw this unease with asymmetrical dependency as being a life-long dimension in my view of the world, neither wishing to fuel dependence in others nor to become 'tied down' myself by such dependency. However, the contradiction about achieving more symmetrical relationships which involved 'balanced interdependency' is that one may need to start from an original position of temporary asymmetry and dependence in order to move towards the former.

A second implication was that I was able to see a little more clearly how Torbert's (1991) concept of a transforming power of balance had not spoken to me at this time, despite its intentions to seek mutuality. I had distanced myself from his developmental model of leadership as I felt it located me as separate-from rather than connected-with the people with whom I worked, and in a hierarchical arrangement rather than in a nested world of possibilities. Yet it is only at the Strategist Stage of development that Torbert begins to describe how his transforming power is exercised: " ... a person exercising transforming power invites mutuality - a mutual exercise of power guided by living awareness of what is currently at stake for the particular systems participating in the transformation." (Torbert, 1991, p56)

He goes on to say that such power cannot be insolently or unilaterally wielded, instead it requires a continual, humble effort to be aware of the moment in all its fullness, transcending

the interests, emotional preferences and theories of all those involved. At moments of potential transformation, Torbert sees transforming power as actively seeking challenge and contradiction because the person seeking to exercise such power is relating to systems that do not initially share an understanding about what is at stake. Its intent is to "empower all who come within its radius of influence, including those who oppose its influence" (p58). Because it seeks challenges and tests feedback for validity, and defers to negative feedback rather than discounting it, it empowers "opponents" as well. The more others are empowered and the closer they come to exercising transforming power themselves, the more nearly mutual occasions of influence become, asserts Torbert.

Despite the spirit of its intent to seek mutuality, I see the language Torbert uses to describe transforming power as being located in the agentic tradition, and as implicitly seeing power as an entity to be used. There is little room in his concept of transforming power for relational concepts which support the work of communion. Although I see Torbert as working towards the fostering of traditions of communion through use of agentic strategies, the spelling out of such a tradition is missing, or at best implicit. It was this which was missing for me in my work with William and the core group.

A third implication was that I could see many ways in which power could serve both the agentic and the communion traditions. Whereas I had previously located myself experientially outside notions of power, now I was able to locate myself within in ways which were congruent with my intentions. I was particularly taken with 'boundary management' as an exercising of power as I sought to occupy that position frequently in the interests of supporting autonomy and interdependence. Similarly, I saw that dimension of power relating to the provision of new or alternative frames and perspectives as underpinning much of my work.

As a result of these considerations I felt freer to consider alternative ways of working within the department. I did not need to feel so tightly bound in with the doctors, there were many areas in which I could continue to practice and I had achieved considerable autonomy in how I could pursue this. Furthermore, there were developments with the ICU which I could pursue without William, although I would prefer he worked with me. I felt I understood in a more tangible and grounded way what Foucault (1984) meant:

> *"If power were never anything but repressive, if it never did anything but say no, do you really think one would be brought to obey it? What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression." (p61)*

So, given this, why was it that I still continued to feel 'caught' and apprehensive about disengaging from trying to bring the doctors with me and getting on with what I knew was possible. It is the finding a way through this dilemma to which I now turn.

'Dissolving the men dilemma'.

Having developed a more extended and deepened analysis of my experience in terms of both gender and power, I felt more able to consider alternatives to the current situation in which I felt 'pulled' back into increasingly rigid patterns of relationship, invited to join the doctors in 'more of the same'. Nonetheless, I still felt perplexed about a reluctance and a tension I experienced in relation to clarifying the boundaries around the work of the psychologists and moving onwards with the ICU development in the face of the two consultant's ambivalence and hostility. I came to understand how this reluctance and tension was informed by my own ambivalence about relationships with men which expressed itself in a 'life script' I had been carrying since childhood.

Dialogues about relationship dilemmas.

I will present here two dialogues about relationship dilemmas which moved me towards resolving my tensions by helping me gain a different perspective on my relationships with men. The first is an 'internal' dialogue within myself, between a 'self from the past' and a 'self from the present'.

• An 'internal' dialogue.

One evening, when writing in my reflective diary about my dilemmas, the only conclusion I could reach was: "I need to exercise agency here." In contemplating how, the question arose for me: 'What would happen if I took charge of Psychological Treatments?"

I then immediately wrote my answers spontaneously, putting thoughts down uncensored as they came to awareness. I have listed them as follows, with another voice in brackets giving a spontaneous counterpoint reflection to each answer as it arose.

- "I might get overwhelmed with referrals (So, you can't say no or negotiate?)
- I might get isolated and left out of the decision making (So, important decisions are made now with you fully involved?)
- I might succeed and get stuck with it and get possessed by it (So, you can't take control, negotiate, set limits, disengage when you need to?)
- I might fail (This is not a strong possibility and therefore not one you are particularly worried about!)
- I might get into conflict with powerful people who are also vulnerable (You have no right to do this, they might fall apart and that will be terrible for them and represent a loss of face. It will be your responsibility to put them together, and in so doing get closer/more involved than you would want/feel comfortable with)

This rings bells with remembered feelings from childhood within my family.

- Couldn't get close to father, a distant man. And if I did, mother might feel rejected and fall apart and I might lose her and be abandoned.
- Couldn't challenge father. He might fall apart. As a child I saw him as a wounded, vulnerable man. Remember looking with overwhelming sadness and sense of loss at his photos of youth and war time, which I could not explain. If I did challenge my father I would win and that would bind me even closer to mother who might possess me.
- Couldn't challenge mother. She would reject me. She used rejection as punishment, and said to me several times when I reached adulthood how sensitive I was to her rejection and that it was the most effective punishment she had with me.
- I felt I couldn't succeed. I would feel guilty as it would highlight sister's lack of success due to her disability (very limited partial sight). I felt I ought to be helping her by including her in my social life but I was having difficulty enough on my own without her as 'socially unacceptable burden'. This is still painful as I feel guilty about having seen her that way and about not doing better in helping her. Even though at that time I did not understand fully the implications of a girl coming from an institution at age 13 to live at home and go to a normal school. All I knew was that I felt embarrassed by her physical and social awkwardness, her thick glasses.
- Paradoxically if I succeeded I would have to take care of her and my mother for ever. My mother would bind even closer to me around success."

This was a healing and revelatory internal dialogue. This 'story' was one I knew well, but had never 'looked it in the face' by verbalising it in this way in writing, a process which gave the knowledge a much more detailed presence and a shape than previously, and one which resonated with my current situation. I could now see that in a current relationship context, where I saw similar issues of conflict, potential separation, vulnerability and dependence, a 'script' I had been carrying from childhood had been activated and was operating in such a way as to constrain me from extricating myself. The effects of this script under these conditions had been to influence me towards minimising differences between individuals (myself included), avoiding confrontation, and 'working hard' to solve both implicit and explicit conflict. It was not that such actions were necessarily 'bad', but when continued past a certain point they carried a personal emotional cost and could paradoxically contribute to the maintenance of existing patterns of relationship, preventing any change to another level or order. In the past I had called this my 'happy families' script, but without knowing in such detail about its origins.

I recognised too that this script had been challenged in my personal life by more recent adult experiences within my family of origin. In that arena of my life, 'things had moved on' and new patterns of relationship had emerged in which there was less dependence and asymmetry, more acceptance of difference, and clearer recognition of boundaries, rights and responsibilities. I knew therefore that 'things could move on' in the work arena, now that I was

aware of how this script was operating for me. I was capable of challenging the current arrangement as I saw it. This awareness was deepened by a second, 'external ', dialogue several days later.

• An 'external ' dialogue.

I brought the above reflections into a dialogue with Jan in the context of asking her to read some of the stories I had written about my professional experiences earlier in NZ (I have not included them in this thesis). This conversation between us added further richness to my understanding of my relationships with men. I reconstructed the conversation from memory immediately afterwards and checked with Jan that she felt it was an adequate representation of the discussion as she recalled it. I have included it here as part of my sense-making of the 'men' dilemma.

Jan. "You know, in all these stories there is another man in the centre of them. You have always had men in your work life with whom you develop a close relationship."

Me. "Yes, although I had not always seen it as 'close'. With some of the men it felt difficult to get close and it seemed we were in more of a struggle together. Though I suppose that is a form of closeness. "

Jan went through each of these men in turn and asked how I felt about them when working with them.

Jan. "In fact, you have been closer to men than you have to women."

Me. "That's interesting, because earlier in my life it was the reverse case."

Jan. "And there is a pattern with all these relationships. They are all men who are powerful and yet often muddled about who they are and how they operate."

Me. "I have been drawn to them all in some way. I think I have been very interested in their power, although with quite a few I have ended up feeling protective and nurturing of them. Take F for example. He inspired strong reactions in people, both ways and at times I certainly got very frustrated and occasionally angry with him, especially when he would consult people about an issue and then half way through discussions I would realise that he had made a decision days ago, and had probably even acted on it by now. The 'consultation' was a way of softening people up for what was to come. But I seldom confronted him head on about it because at some level I just accepted that was how F was. I remember some amazingly tense scenarios, with awful conflict between him and certain staff members, and he would behave as if it wasn't happening, then do something later behind the scenes which solved the immediate conflict but never changed the nature of the relationship. The same thing would erupt again six months later. I was forever reframing him for people who wanted to confront him head-on. My approach with him was always to listen and then tell him how I saw things. Maybe that was oblique or even dishonest, but I had

the feeling that we both knew what was happening and he appreciated not losing face that way."

Jan. "As I see it, these men have not always been sure what to make of you." (she illustrates with examples about comments they have made or how they have behaved towards me.)

Me . "I wonder if that is because with each of them I get to a certain point where I feel I cant get any closer without losing my authenticity. In many of those examples I end up feeling: 'This man obviously would like a closer relationship, but I am not prepared to do so because I would feel I have to compromise who I am. He does not see the world as I do, we have different values.' I do not let them see any further who I am. I don't want to lead them into thinking we are the same or that I am willing to go along with how they want to practice. On the other hand I don't want to highlight the differences to the point where we can't work together. Sometimes it is a case of me deciding 'I have to work with this person and if we do not get along at a certain level and find things in common, then my job will be very hard to do.' But it is not as mercenary as it sounds because I find it easy to discover things to appreciate or like and admire, and often I am also curious about them as people if they are charismatic or powerful. Hmm, I wonder if I use their power in a vicarious way, not owning power for myself but 'hide behind their throne' as it were."

Jan. "What I see you doing is exploring their power, then finding it is invisible. You then realise you can be more powerful than them."

Me. "That sounds a bit grand but it feels true in some cases. Then I back off, not wanting to hurt them."

Jan "Or destroy them."

Me. "God, just like my relationship with my father. I have very early memories of seeing my father as vulnerable and needing nurturing. I had some deeply felt sense of sorrow and loneliness about him, although I couldn't articulate it in that way in those days. But I had recurring dreams about him in that way as a child. I do not know whether I gained that view from some of my mother's stories about him, he certainly never talked about himself in any revealing way (I detour to talk about what I learned through her of his past). Although, as I saw it then, my mother was more inclined to be angry and critical towards him than compassionate. I have a very vivid memory of the only time he smacked me as punishment for something I had done. I remember deciding how I was going to react to this, and decided I had better cry because if I did not then he would look humiliated. I desperately did not want him to look foolish, which in fact I thought he was being because I was very contrite about what I had done and didn't think I needed punishing to point out my error. I also remember thinking: 'He is showing some attention towards me as a father, and I like that, so I will cooperate by responding as I am meant to.'

Yes, I believed I had the power to 'destroy' him. Hmm, I wonder if my relationships with men continually mirror this first relationship. All very Oedipal, or is it more mythological, a case of 'wounded by father absence." (laughing)

Jan. "Well, if it's Oedipal, then its very important not to kill off father because you are then left with mother to care for and can never get on with your life."

Me. "Absolutely, and in all these jobs if I 'destroyed' these men, in other words was more successful than they, I would have been left with the organisation to look after. And in all these cases I did not want to remain with it on a long term basis, in a 'marriage'. So maybe this is all reducible to an 'unresolved Oedipus complex' after all."

Jan. "Or perhaps that was who you were as a person even then, and that is why you picked up on your father's pain."

Me. "That is something that connects all these men. They were wounded in some way, but I recognise now they all had qualities of the feminine which I was drawn to and that was part of their charisma."

Jan. "Yes, but they would not acknowledge this about themselves and hence the feminine was never given a chance to heal the wounds."

Me. "You know, that was something different about entering this job. I did not want to repeat the pattern of short involvement and move on. I wanted to stay around for a while, feel like this is where I belong and see things through to later stages of development. And isn't it interesting, this time around I did take the risk and 'killed off' the charismatic and powerful wounded man. And do you know, in the middle of our confrontation he offered to stand down and for me to take over? I remember part of me being curious at the time at how I responded. I felt completely neutral. I said: "If I thought you really believed that it would be the best course for the department, then I would consider it seriously. But if you are asking me would I like to, then no." "

Jan. "But he survived."

Me. "Yes. I did not feel any responsibility for his pain, although I felt for him that he was in pain, he was deeply distressed, tearful and self deprecating . Although later he was not willing to discuss things in any depth and he slipped into 'you are the one with the problem'. We had several stand up rows and yelled at each other, then retreated. And our relationship has changed. I felt we would repeat the same pattern if I pursued and so I backed off. I decided it was probably I who had unrealistic expectations about how we could work together. Look what happens when you push things past their usual boundaries.

But what's also interesting is that now I am in a position in my life, and I feel the research has brought me to this point, where I am having to face up to the nature of power for myself and how I use it. Very interesting!"

Implications for 'moving on'.

The immediate implications of these dialogues was that I felt an easing of the tension I had been carrying about the relationship impasses 'upstairs' in the Core Group. I felt a 'knot' had been 'untied'. I now understood my contribution to the bind I had been participating in, whereby the more I (and others) wished to move towards a more collaborative working relationship with other groups and departments outside our own, the more unstable things seemed to become within our department. And, correspondingly, the more I attended to that instability by 'working hard' to bring the different participants 'on-board' with the possibilities for change, the more remote those possibilities seemed to become. And the more remote the possibilities, the more I alternated between, on the one hand, 'working hard' and on the other giving up in despair in the face of seeming 'resistance'. This pattern of 'instability' was in fact becoming increasingly more stable over time the more we all continued to participate in it.

With my new understanding about my own contributions to this impasse, through the recognition of the role my life script had been playing and through re-positioning myself within the concept of power, the following reflections occurred to me. Firstly, I recognised that I no longer needed the affirmation, permission or support of the two consultants to 'move on' in developing the ICU. Nor did I need it in taking authority to develop psychological treatments to the next stage which was to collaborate with other groups across the Trust who were working with similar problems. Whilst it would be desirable to have their affirmation and support, it was not necessary. If I risked unresolvable conflict and the possibility of separation and dissolution of the core group and the department as we knew it, then so be it. Perhaps it was needed in order for change to occur and I could now countenance this risk emotionally as well as intellectually. I saw more clearly than before how I had been playing 'happy families' and that the survival of all the members was not dependent on us conforming to my notion of what constituted a 'happy family' arrangement.

With this realisation came a sense of sadness at the possibility of the things I had worked hard for not coming to fruition. But on the other hand I could appreciate more fully that each of us as individuals has to make our own journey at our own pace. My hopes of offering William an alternative perspective about collaborative forms of practice had to be tempered with the realisation that his relationships with his medical colleagues both created and were created by a different set of contexts for experiencing and understanding the world. The consultants' professional world was structured by different sets of practices and discourses and by my offering my world views in contrast I may have been contributing unhelpfully to William's sense of dissonance in finding his own personally authentic form of practice. If I took initiatives from this point on which were congruent with my own sense of values and purposes, then I had to leave it to both William and Stewart to choose whether or not they supported or followed. What was clear to me was that I needed to take the initiative myself in order to practice authentically and avoid continuing to pay the personal and professional costs incurred to date. My unspoken sense of guilt at leaving others behind seemed redundant now.

The second implication arising from my new perspectives was that I no longer felt it necessary to mask my own competence or 'power' in relation to the two consultants. In Stewart's case I could risk the possibility of criticism and rejection, and in William's case I knew that he would 'survive' without my continued attempts at coaching and supporting should our relationship change further. My more developed and multi-dimensional conceptualisation of power and my new understanding of my own sensitivity to other men's vulnerabilities allowed me to have greater choice about how I participated in the Core Group. I recognised that I was less dependent on the consultants than I had implicitly assumed to date. It was with sadness that I accepted that I was not central to the consultant's world and they were not central to mine. But, all parties would 'survive' any changes in patterns of relationship.

'Moving on' in practice.

At this point I wish to give only a very brief account of the initiatives I took as a result of my reflections above. The initiatives were small but significant and allowed me to move away from the 'stuckness' I felt and to contribute more actively to developing new directions in services.

My first initiative was to begin a survey of the need for psychological treatments across all the community and outpatient services delivered to the local district. I wanted a clearer picture of the types of problems being presented in order to assess what psychological skills, knowledge and competencies were needed to effectively work with those asking for help. My reading of the situation was that those clients who required longer term work presented with problems no different from those worked with in other parts of the Trust. For example, many clients revealed a history of childhood sexual abuse and were increasingly asking for assistance in dealing with the adverse consequences which had trailed them into their adult lives. Clients presenting with eating disorders were another example. Our department could not meet all the treatment needs alone, but in collaboration with other workers and groups from across the Trust, we could achieve an 'economies of scale' in sharing resources which could be mutually beneficial for all concerned. To initiate this survey I began discussions with the Community Team and began planning processes for collecting this data.

In parallel to this was a second development in the Core Group in relation to the ICU which by now was taking concrete shape with recruitment of staff and the refurbishing of a building. The initiative I took was small, but to me led to the most significant changes. I announced in the Core Group that , despite their reservations about our department having taken on the ICU and despite their doubts about whether they would continue to support it, I had personally committed myself to its development. From now on I would be formally assigning three out of ten sessions per week of my time to it. Furthermore, I wished to employ more psychology time within the department to support my work with complex cases while I was absent. There was silence and I remember clearly that Stewart looked stunned and William looked awkward and uncomfortable. However there was no rebuffing of my statement and only minimal discussion of the implications of this as I presented how I would be managing the change. I had

broached this subject on a number of occasions so the content of my announcement was not new, It was my making the announcement assertively and assuming they would support it which was new.

Although the old processes within the Core Group, as described above, continued to re-emerge periodically, from this time onwards I no longer felt paralysed by them. I felt strongly, from my own perspective, that by making my announcement in the Core Group I had symbolically marked a boundary around my 'territory'. This signalled to myself and others that I was assuming a more explicit and active authority over how psychologists would contribute to the services in the future.

By paying attention to personally painful dilemmas and discovering the role of life scripts, I expanded my notion of Torbert's (1991) requirements of a transforming power, namely that contradictions and incongruities at all levels of an acting system must be open to inquiry. I will finish this chapter by reflecting on the significance of life scripts for inquiry.

The significance of life 'scripts'.

This had been an interesting demonstration for me of how, in terms of Cronen and Pearce's (1985) differing levels of context, life scripts could enable a different dimension of meaning to be taken from or constructed about events. Of interest to me were the circumstances in which this meaning became 'accessible' to me. Firstly, it arose in relation to a personally painful crisis or dilemma. Secondly the type of reflective process which enabled me to become aware of this meaning was a two-fold one - writing and conversation. Both are dialogical.

My spontaneous writing in reply to my question of myself 'what would happen if you took charge of psychological treatments?' revealed a dialogical relationship with an imagined audience of readers, as well as an internal audience of 'different selves'. There was an element of inquiry and challenge in this dialogue, as witnessed by the alternative voice in my counterpoint replies to the question. In the conversation with Jan there was an audience of a particular other as well as myself. The nature of the relationship with Jan at the point of inquiry is clearly embedded in the complexity of a marital relationship, but at such times when we conversed about our research, there was a strong element of a trusting peer supervision relationship. I recognise similar qualities in trusting and close relationships I have with professional peers. It occurred to me then that the discovery of life 'scripts' and how they operate requires a kind of relationship to oneself and others in which there is trust, acceptance, and at the same time a willingness to challenge and inquire. Whether the context of inquiry be a particular form of supervision or research, the ability to utilise the concept of 'life scripts' requires such a relationship.

What also became clear to me in the final production of this thesis, within the narrative inquiry framework, was that life 'scripts' are not brief statements but rather are storied in form. While it is perhaps possible to summarise such stories in a short phrase, this does not capture the interactional nature of them and their construction. Furthermore, they are not the only

available stories. They rest alongside other stories about the past which emerge or submerge according to the particular context of remembering or re-construction. Re-thinking about 'scripts' as stories allowed me to reflect back on my relationship with William and the story-telling we engaged in about our lives and I saw then that we each had probably glimpsed the other's life 'scripts' which had in turn been a part of the sense we had made of each other and events within the relationship. However, I believe it requires a mutually agreed and explicit framing of the relationship in which permission is given to inquire more carefully and intimately into the presence of life 'scripts'. I do not see myself as having achieved this with the other actors I have written about in this research narrative, apart from Jan. However, there are other individuals with whom I have developed such relationships, who I have not included as part of the research field but with whom I have discussed aspects of the research and my learning from it in some depth. These individuals are not given an explicit voice in this narrative, so I will comment on their significance in the next and last chapter.

What is clear to me is that painful dilemmas signal the opportunity to inquire into the presence of 'life scripts' and how they may be operating as one context for taking or creating meaning about the events in question. I carried this learning forward from my research into supervisory relationships and I now feel more comfortable about using a narrative or story telling frame for inviting the other person to reflect on how life 'scripts' might be operating at points of 'stuckness'.

The events described in this chapter represent the second of what Denzin (1989) terms epiphanies, or moments of revelation in a life story, which arose for me in the context of conducting the research. The first 'epiphany' occurred around my learning about gender. The re-conceptualising of power both arose out of and in turn informed my personal learning about gender and it is at this point, at the closing of this particular loop, that I have punctuated the 'end' of this research venture. In the next and final chapter I will reflect on the research journey as a whole and will draw some lessons from it.

15. TOWARDS THE RE-CONSTRUCTION OF A CLINICAL PSYCHOLOGIST: A PAUSE FOR REFLECTION.

Introduction.

In this final chapter I will look back on my original broad research questions and reflect on the developments in my learning about them. I will do so from within the three domains of personal/professional, research, and developments within the work setting.

In writing this last chapter I was aware of a 'traditional researcher self' (still present) which was tempting me to go back to the original questions I was asking of the research, to tidy up the loose ends, collect together my findings, sum them together into some coherent conclusion, then look at what remaining or new questions there are to be asked of future research. I felt I ought to be able to do this. But more strongly there was a 'new paradigm researcher self' which asked "from within which of the many perspectives you have considered are you going to do this?"

In attempting to resolve this, I reflected back on the core questions I was asking of myself at the outset.

- "What is it I do as a clinical psychologist and how can I account for this?"
- "How is it I participate in multidisciplinary teams and can we learn together about what we do?"
- "Can this organisation be one which is 'alive' to itself and the world, and how can I contribute to its being one?"
- "If I am a clinical psychologist, how much can I belong in this professional body given that my world view is at odds with its publicly espoused world view?"
- "Can I find an alternative form of inquiry which answers these and other questions within my world view?"

In considering these questions, I believe I have learned much and I see myself as having commented on the learning throughout my writing so far. However, there are things which have been learned which are only implicitly contained in this account and to which I now wish to give more voice. To do this I am going to draw upon the metaphor of 'boundary rider'. I will sketch this metaphor and then use it as a position from which to make my learning more explicit.

Boundary Rider.

This metaphor was offered to me by a colleague who worked in another organisation, at a time shortly following the period I have reported in this research. She was a practising clinical psychologist and family therapist with a part-time university position as a teacher and researcher. We shared similar interests in this way and she had been a significant role model in being the first psychologist I had heard presenting qualitative research at a conference arranged for and by psychologists. The mental healthcare organisation in which she worked

as a practitioner was planning the development of new services for which she would be responsible, and at her suggestion had asked me to be an external consultant to support this. The work involved my helping in the planning, marketing and implementation of new services, to be followed by an on-going clinical consultation role. After my initial meeting with the people involved, I asked her why she had suggested me (I knew several others had been considered by the planning group). She replied that she was committed to having a psychologist because they were systematic and would provide the tools for basing the new developments on a sound empirical footing. She had suggested me in particular because I was a "boundary rider", someone she saw as being able to move between the different professional groups within mental health, and between the worlds of systemic family therapy and clinical psychology.

This metaphor 'sank home' and I dwelled with it for some time. I was surprised at how much it connected with how I saw myself, how it captured much of me as a person and as a professional, and how it offered a connecting metaphor for many experiences through the research. I saw myself as having been a boundary rider for much of my life, moving between different groups and perspectives, seeing each as offering partial but not whole 'answers'. I saw that I had 'ridden the boundaries' between cultures in New Zealand in a similar way that I had ridden the boundaries between different professional and functional groups in the research. Furthermore, it captured my experience of moving across and between differing bodies of ideas in grappling with research.

This metaphorical role or position has its strengths and weaknesses. The moving between and across perspectives had allowed me to see new possibilities and the freedom to seize new opportunities for change. On the other hand it had sometimes seemed a lonely and therefore vulnerable position. Sometimes spending more time in one territory than another resulted in me becoming 'swamped'. At other times I had kept one foot too much in a preferred terrain and had not therefore been able to step out of it sufficiently to gain a new vantage point from which to map it more extensively. This had been the case with respect to traditional research traditions, gender and power.

I do not see the boundary rider as offering the 'true' perspective, or better perspectives, just different ones. In 'riding the boundaries' one (and in using this term 'one', I am offering this notion to any person who relates to it or who wishes to adopt it) is in a position to make and hold connections between previously separate frames of meaning which provide new frames or vantage points for participants, including oneself. If these new frames offer participants the potential for mutuality, increased self awareness and reflexivity then the connections will hold, and the boundary rider can 'move on' without needing to reside permanently. The new frames will get picked up and established in that setting. Alternatively, if such attempts fail, then the act of 'moving on' in itself may release participants, including the 'boundary rider' to experience and 'see' things differently (for example, my 'moving on' in the Core Group in chapter fourteen).

I am not sure what answers this metaphor, which is implicitly connected to metaphors of landscape, provides to the ontological question posed by Lincoln and Guba (1985) of 'what is there to be known?' To some extent the metaphor, with its accompanying notion of territory or landscape, maps onto the critical tradition of implicitly accepting a 'reality out there' but one which can never be fully apprehended because of different value positions. If territory equates analogically with the social world or the world of meaning, then the metaphor is apt - we can never truly map the full nature and extent because it will appear differently according to our vantage point. At one level, I am comfortable with this experientially because, within the metaphor, one needs familiarity of place - to return to or depart from - in order to provide grounding and to prevent being lost in a world of multiple possibilities. Furthermore, one learns preferred pathways through the terrain, or has favourite spots because of the views offered. But like any pathway overly-trodden, it can become a rut. And any spot visited too frequently loses its 'difference' and appeal. I believe any experiential territory is bounded by notions of certain 'givens' of human existence such as birth, death, change, ageing, uncertainty, need for sustenance, shelter, belonging, and so on. To this extent, there can be seen to exist a universal set of 'realties', independent of our knowing.

At another level, I am wary of the metaphor because it can too easily overlook the extent to which the territory is also a constructed one. The meaning assigned to the above human 'givens' are constructed differently according to place in culture, age span, gender, social grouping and so on. To this extent the boundary rider must carry an awareness about the extent to which the notion of boundary itself is a socially constructed one and experienced personally as unique by each participant.

In his book 'Songlines', Chatwin (1987) describes his understandings of how the Australian Aboriginal people view themselves and the geographical territory as co-created. They bring the physical landscape 'alive' through song, imbuing it with life forms (including spirit) and giving it a presence with which they interact. Different parts of the geographical territory require different songs, and in moving about across vast distances, the Aboriginal people sing the land alive as they travel. They are required to keep the land alive by singing it and this seems to be one of the purposes of long 'walkabouts'. In this way, the songlines also act as maps which guide their progress and demarcate territory which is inhabited by both people and spirits. But equally, the giving life to landscape in turn gives life to them as it co-defines realities and nurtures and holds a mutual interdependence between people and the land. Bateson (1979) in his book 'Mind and Nature; a necessary unity.' in which he presents his concept of mind as 'pattern which connects', alludes to this in posing the conundrum of whether a tree falling in a forest makes a sound if there is no one there to hear it.

Conceiving of the Songlines process as a boundary riding of sorts (although this may be stretching it too far) gives rise to the idea that it is both life-giving as well as life-receiving Thus my concept of boundary riding contains a paradox or contradiction, that boundary riding can

lead to new possibilities, but is also needed to ensure these new possibilities are maintained. As with the Aboriginal people, the role of boundary rider in other cultures and social groups needs to be continually peopled over time. Perhaps this is one of the roles of the agentic tradition, in the service of communion, structuring experience to avoid undifferentiated chaos.

Chatwin himself, as a non-Aboriginal, can be seen as a boundary rider, opening up visions of other realities. These themselves are partly of Chatwin's construction as an 'outsider', but the connection he provides is awe-inspiring. It may also pose risks to the Aboriginal people. Who knows what will happen to this sacred knowledge if it becomes public domain and is not afforded the reverence and ownership it is due? I am reminded of my involvement with the cross-cultural handbook in New Zealand where I was given a strong reminder of this possibility.

A boundary rider needs to respect that there will be sacred or private knowledge and be prepared to participate in the process of construction of boundaries which both protect and keep implicit as well as open up and make explicit. In this way the boundary rider will be reminded that such construction is social and will be guided by all participants - not only those immediately involved, but also wider 'audiences'. The boundary rider will always be faced with such contradictions and dilemmas.

Finally, the metaphor of boundary rider captures for me the notion of the 'reflexivity' - being able to locate, in so far as possible, that part of the terrain one is standing on in order to make observations about personal experience and the world as seen from that very vantage point. The identification of that vantage point relies on the existence of others from which alternative views can be taken and in so doing allows the mapping of the contours of the terrain under consideration. My experience over the course of this research has been that the identification and location of vantage points has arisen out of a dialogic process - between 'different selves' or between self and other/s. Therefore I see reflexivity as a concept which applies to acting systems, including but not exclusive to , the self. Whilst reflexivity can be experienced as a personally developed state of awareness, it is achieved inter-subjectively.

The seeing and the living of boundaries allows for a curiosity which fuels transformation. While this transformation is inter-subjectively constructed and lived, it is also personally experienced and it is this contradiction which a notion of reflexivity must hold. I prefer the term 'inter subjective' rather than 'social' because it allows for the idea of a reciprocal relationship with all living things.

Within the concept of power as I have drawn it in this thesis, I see my role as boundary rider as the exercising of a relational form of power - providing, co-creating and holding 'frames' in which more transformative action can occur and out of which new meaning or stories can emerge. It also taps and requires other sources or forms of power, both personal and structural. It requires personal power in terms of autonomy, self esteem, expert knowledge and sensitivity to the issues at stake. It requires structural power in terms of handling uncertainty

and risk and being central to organisational or group tasks. In other words, the exercising of power through boundary riding requires the holding of multiple perspectives on power.

Having sketched my conception of the boundary rider metaphor, I will now use it to provide some commentary about the extent to which the research answered my original questions, and the way in which it helped with this. I will turn first to the 'research' domain, reflecting on the strategies for inquiry which I used and what emerged from them, using the boundary rider metaphor to view this from different perspectives.

Reflections on strategies for inquiry.

I see the research as having developed two methodological strands: an action research or action inquiry strand which paid attention primarily to knowledge gained in and for action; and an interpretive strand which paid attention primarily to knowledge about action and about 'being' in the world. Each fed the other, but I will deal with them separately in turn.

The Action Inquiry strand.

I began the research with some of Torbert's earlier work which he termed Collaborative Inquiry, but which in his later work on the power of balance in organisations he termed Action Inquiry. I think this framing had an interesting effect for me. Part of my unease with myself as an investigator using Collaborative Inquiry - the four territories of experience and experiments in practice - was that I felt I had failed to gain 'collaboration' from others in the terms Torbert defined it, namely, that others in the field come to explicitly share the model. While William had read about the model, it was not something which he talked about in relation to himself and so it did not provide a language for commenting on or explicitly inquiring into our relationship. While there were many ways in which we collaborated, I did not see the two of us as being engaged in a Collaborative Inquiry. The effects of this framing maintained a continuing edge of anxiety on my part about the extent to which I was 'doing research'. I see in retrospect that it was this which 'turned' me towards writing as a means of having a dialogue about experience.

In his work on the power of balance, Torbert nests this form of inquiry within a wider notion of the workplace as a potential community of inquiry dedicated to continuing quality improvement. His model of power and leadership is intended to provide guidelines for leaders on how to promote such a vision. The notion of Collaborative Inquiry is replaced with that of Action Inquiry, a means of working towards mutuality in relationships and of empowering self and others. This recognises that others may not share the same frames or, in Torbert's terms, be at the same level of leadership development. Despite the limitations of this which I encountered and described in chapter fourteen, the term Action Inquiry better suits and frames how I used his ideas in practice.

It was only in a later re-reading of Torbert that this distinction became clear to me. Reason (1994) reviews a range of what he calls 'Participative Inquiry' approaches, Torbert's Action Inquiry among them. He notes that it is only when individuals are at the strategist stage of

development that collaborative inquiry becomes possible. I remain unclear as to whether all participants in a Collaborative Inquiry need to be at this level of development for it to be an effective interpersonal strategy for inquiry. Certainly, my experience was that it requires participants to share a willingness to explicitly investigate their personal experience and a set of beliefs that worthwhile knowledge will emerge from such a venture.

My own sense of how action inquiry helped my research and the learning from it is as follows, and these comments address issues of rigour of knowing as I see them:

- It kept my focus on moment to moment experience as the primary source of data and also as a source of knowledge. In Heron's terms, I learned to trust the experiential, presentational and practical forms of knowledge equally as much as the propositional, the latter previously having more 'weight' with me. I learned how direct experience could lead to theory, and back again. But more importantly, I learned to look for the grounding of any theory in my own experience, to test out how it worked for me in my circumstances and to trust more my own sense making than the theory. Theory is only useful to the extent it serves experience. I feel I understand more the feminist critique of social science. I do not lay this outcome wholly at the feet of Action Inquiry by any means, but for me it provided a framework which kept my 'nose to the grindstone' of immediate experience.

- The interpenetrating attention span acted as a framework for paying attention to incongruities, within myself, between myself and others and between groups. I think I came into the research being able to pay attention to interpersonal process, to pay close attention to feedback and to think about what was happening in the moment within a number of contexts. Family therapy training had taught me this. However, I think the structuring of the interpenetrating attention span helped me include my own self more in the frame, to the extent that it kept holding up incongruities for me. It was an awareness of incongruities and the importance for learning which action inquiry places on them which led to personal 'breakthrough' learning about gender and life-scripts. I am now more comfortable across a range of practice situations in allowing 'the moment' to give rise to what might usefully happen next.

- I am less clear about the concept of experiments-in-practice and how they might usefully be defined. The deliberate and clumsy use of these, as in Eddie's story in chapter eight, lead to a sense of inauthenticity, both as a practitioner and as a researcher. However, I consider in retrospect that my actions in the marketing meeting in chapter thirteen can be seen as an experiment-in-practice. In this case it was spontaneous and was driven by a need to behave authentically, rather than by a pre-planned strategy to achieve a certain outcome. Nonetheless, both efforts produced personal learning, although the outcome in the marketing meeting was more in my hoped-for direction.

I recently ran a workshop for psychologists on the concept of reflexivity and how it applied to the process of supervision, and I used some of Schön's (1983) notions of experiments in problem solving from his concept of the 'Reflective Practitioner'. He sees experienced professionals drawing on three different types of experimental approaches in confronting unique and complex situations: the *controlled* experiment, using inductive reasoning, in which hypotheses are selected to the degree that they 'fit' with the data encountered in the situation; the *exploratory* experiment, a 'probing' activity to get the feel of things; and the *move-testing* experiment, acting to produce an intended change. The Reflective Practitioner engages in all three at any one time. This more multiple description allows me to see that some experiments-in-practice in Torbert's sense may have differences in emphasis to which the practitioner needs to be finely attuned.

My view is that experiments in practice need to be conducted in the context of a vision about what is possible and preferable, what is personally authentic, what is inclusive of others and allows for the possibility of meaningful participation, and what allows for the honouring of multiple perspectives. This can have different implications according to the time frame in which the relevance and timeliness of any action is judged. Sometimes short term hoped-for outcomes can be held lightly and forgone in the pursuit of those which are longer term and more tightly held. This acknowledges the role that anticipation about future states of affairs has in guiding human behaviour. I am not sure this equates with 'purpose'. The conducting of experiments in practice must occur in a context of values which behoves the practitioner to be able to be explicit about those which matter to them.

Torbert (1991) sketches his vision of a living inquiry which extends the principles of action inquiry into all areas of life towards justice and mutuality, and a spiritual dimension of self-renewal and openness to "eternal questions"(266). He sees the acquisition of this quality of awareness as needing a life-time commitment, as being facilitated by 'near death' experiences (including the symbolic) and as needing a life-time circle of friends willing to accompany this development. He likens progress to a "stumbling gait", only occasionally having moments of experience in which one feels congruence across all domains.

I see contradictions within his model between the vision on the one hand, and some of the theoretical models underpinning it which in my experience tilted me away from the feminine/communion domains towards those of the masculine/agentic. I have mentioned these in chapter fourteen in writing about power. I see Action Inquiry as working for agency, as potentially being in the service of communion but with this being implicit and unvoiced. I see Torbert as seeking this intuitively but unawarely. Hence action inquiry could be seen to be gender-blind.

Taking a 'weaving' metaphor to describe the research process, I see Action Inquiry as providing an open intersecting weft and warp webbing or structure for paying attention to

experience in the midst of action, and for testing out knowledge as to its relevance and utility in any particular situation. However, it does not suggest what experience it is important to notice and in what way to assign meaning. In addition I see it as being predicated on valuing action over being (as reflected in its language) and so potentially missing important dimensions of human experience. This structure or 'webbing' requires material to be woven into it in order to give texture and richer meaning, and it is the interpretive strand which provided this for me.

The interpretive inquiry strand.

Within this strand I will include both Naturalistic Inquiry and Narrative Inquiry.

• Naturalistic Inquiry.

Here I will reflect on quality and rigour of knowing from the perspective of Guba and Lincoln's (1989) criteria for Authenticity, namely:

- *Fairness* - the extent to which the different constructions and their underlying value structures are honoured.
- *Ontological* authenticity - the extent to which the participants' own constructions are improved, matured, extended and elaborated over the course of the inquiry, to the extent that they have more information and are more sophisticated in its use.
- *Educative* authenticity - the extent to which individual participant's understanding of and appreciation for the construction of others outside their stake-holding group is enhanced.
- *Catalytic* authenticity - the extent to which action is stimulated and facilitated by the evaluation process.
- *Tactical authenticity* - the extent to which the stakeholders and participants are empowered to act.

I see these criteria as being interpretive in the sense that they are concerned primarily with epistemological issues. Although they are concerned with 'acting in the world', their primary emphasis is on the degree to which any evaluative process honours and develops the constructions of the participants.

There is a tension for me in using these criteria at this stage in reflecting on the research as it has emerged. As I had originally envisaged a more explicitly shared research venture, these criteria seemed relevant. However these criteria are now harder to apply in that they presume the explicit involvement of others in an inquiry process, even though that process is conceived of by Guba and Lincoln as one of programme evaluation. Also, they are predicated on the assumption that more sophisticated and elaborated constructions of the issues at stake lead to action which is more empowering and emmancipatory. They do not lend themselves easily to action inquiry which has its focus on knowledge in and for action, and in which the initiating researcher is an active participant and 'stakeholder'. In the day to day social setting of my organisation, knowing who to involve and how in advance is difficult to predict. This is in contrast to the selection process for respondents advocated in Naturalistic Inquiry and the Hermeneutic Dialectic Process.

I also found them difficult to map onto Action Inquiry because of the changing and emergent nature of the research focus and process. To the extent that 'complex cases' provided a useful focus for holding my research questions, the Hermeneutic Dialectic Process provided an heuristic map to guide the construction of good practice guidelines. However, it became clear that this focus could not hold all my questions, and in my pursuit of them through Action Inquiry strategies I moved over a range of issues in the pursuit of mutuality and collaboration. There was no 'final product' or case report to which the set of authenticity could be applied, and no bounded inquiry process which enabled the degree of triangulation and cross checking implied by the process.

On the other hand, the set of authenticity criteria contain a set of values with which I strongly agree and the holding of them requires a continued questioning of the nature and direction of any research venture. They provided a useful heuristic for me at the level of reflecting about the overall nature of the research process and in representing action and experience in writing

With these caveats in mind I will reflect on the degree to which my research met my understanding of these criteria. I will return to these again later when I reflect upon the research within the Narrative Inquiry perspective and consider some contradictions thrown up by the use of these criteria. At the outset I considered that Fairness, Catalytic and Tactical authenticity were the criteria most applicable to action research. As the latter two are dealt with more directly and extensively by Action Inquiry, and as I have commented on these aspects already, I will dwell with Fairness. This criterion is the one I feel most personally challenged by.

• *Fairness.* This was useful to apply to myself and my sense making and this criterion has had a primary organising influence over my own actions and reflection. However, I find it difficult to attest to the degree to which I have honoured those of others who people this research account. It was a case of doing 'the best I could under the circumstances', given the limits of the relationships between myself and others and their willingness to inquire with me. I have been motivated to honour this criterion, but given the 'hurly burly' of day to day life and the close engagement required of the action inquirer, my own values and prejudices will have prevented me from doing full justice. I have felt anxious at times in writing the research that I have presented others in a negative light in relation to the action and I wonder if I am too judgmental and 'holier that thou' (an echo of feedback from others in my teenage years). On the other hand, I rationalise that I have been focusing more on difference than similarity in what I see as the constructions held by the actors, and that this has been within one overarching context, that of creating change in providing an improved service for clients. This is a position which invites strong feelings in me and I cannot let matters rest easily if I see possibilities for a more liberating state of affairs. So there is often a contradiction among my own set of criteria for personal authenticity - respecting that each is trying to do their best given their life history and current circumstances, versus feeling strongly that I must participate in

creating more liberating structures and in so doing challenge attitudes and behaviour which seem counter to this.

Keeney and Ross (1985) in writing about social constructionism in family therapies observes that there are two domains in which the therapist constructs meaning. One is the domain of the verbal in which the therapist inquires directly through conversation with the families about the meanings they attach to events. The other is the domain of interpersonal behaviour which he calls the 'political'. Through close observation of the sequences of action, the therapist also constructs meaning about the construction of meaning in the family. In other words, the family can be seen to behave 'as if' they held certain beliefs. This, perhaps contradictory, frame can be offered to the family as a new context in which to consider the issues at hand.

It is this latter domain which is often more available in a moving world to the action inquirer, and one on which I often relied in order to construct meaning. In writing this now, I reflect that I perhaps too hastily relied on the 'political' and the metaphorical, and not sufficiently on creating space to inquire more conversationally into the constructions held by others.

A recent event highlighted this for me. A member of the community team (a social worker/counsellor) left after ten years in the job to take another which represented for her a growth in her professional development. I had been her clinical supervisor for the past five years, but this was a relationship which had matured to include mentoring and peer reflection as well as focused supervision about aspects of her work in which she felt 'stuck'. She wrote to me after leaving, thanking me for my "support and advice over the years". The sentences which I felt most affirming of our relationship read: "The really important thing you did for me was to treat me as an equal colleague capable of doing good work. I think that gave me the confidence to take risks and grow professionally". Leaving aside the differing natures of people's professional roles, skills, abilities and competencies, and leaving aside the hierarchy of expertise implied in a supervisory relationship, I need to consider how to import a more conversational form of inquiry from a supervisory context into daily dialogue around work issues. (Not that I wish to give up strong opinions.)

The remaining two Authenticity criteria, Ontological and Educative, require a different process than the action inquiry/ story-telling methodology I have used. Although these are two hoped-for outcomes in any inquiry which seeks to generate more liberating structures, it requires the voices of the other participants to be directly heard in a way which I am not able to provide here.

In relation to myself, I believe my inquiry into my own practice substantially met ontological authenticity and this has been a core component of the research. As for Educative authenticity, my thoughts in relation to Fairness apply here - I wish to be more rigorous about this in the future.

From the position of the Boundary Rider, I see this set of criteria as locating me as an individual participant researcher at a distance from events, and as loading onto propositional knowledge. While this is extremely important in terms of reflecting about action and arriving at an informed analysis, it presumes much about the process of how the researcher/participants arrive there. The process of writing and story-telling is the other strand which tells of this 'arriving'.

It is to Narrative Inquiry that I now turn in order to review the research process, and in so doing put a different slant on issues of quality and rigour of knowing.

• Narrative Inquiry.

Ironically, it is in some way because of the difficulties I experienced with initiating both cooperative and collaborative inquiry that I moved to story telling as a way of both recording and communicating about experience in the research field. Because I did not see myself as having a group of collaborative co-researchers with whom to dialogue about the experiences I was having, I turned inadvertently and intuitively to dialoguing with an imagined audience, and then to a limited actual audience of readers, through writing.

It was only after the four year period of field work and creating field texts, when I had reached the phase of having to make broader sense of all the data I had collected for producing this research text in its final form, that I arrived at Narrative Inquiry as a more embracing interpretive framework for doing this. It is this framework that has influenced the final form of this thesis and which has helped resolve some of the tensions I had experienced about representing other people in text.

One of the tensions I have carried is about not having given this writing to others who are in my stories to read. On the one hand, I was writing about them and surely they ought to have a voice about my representation of them. On the other hand, my accounts were also personal and inward looking, directed more at examining my own professional life than that of others. As these stories became more personal, moving outside the immediate professional setting, in both time and place, they became more an inquiry into how I accounted for my own actions and theorising. I have felt self-protective about this as well as other-protective, slightly vulnerable and unsure about how others would read such stories, and aware that the stories take life as much from the writing as from the prior intentions or 'actions in the world' which they represent.

As it became clearer that I was 're-constructing' an account about myself and my life through the research, this thesis has become an 'autobiographical' representation of my journey. The imagined audience for whom I have written has shifted from those who people my stories to those who similarly wish to travel their own version of the same journey as researchers, who similarly wish to develop a more encompassing self-and-other-awareness, who wish to participate in co-creating a more reflexive social world. I feel able to give this thesis to those who wish to be 'fellow travellers'.

Weaving the strands together.

Finally, I wish to comment on the relationship I see between the different strands of inquiry strategy, starting with Narrative Inquiry in relation with Action Inquiry. Narrative Inquiry as I have used it, as writing about experience, complements the 'on-line' knowledge-in-action generated by Action Inquiry through providing 'off-line' knowledge generated by an inward dwelling reflection about the events under consideration. Considering all representation of experience as storied allows the writing about experience to be done within narrative criteria about what constitute 'good stories'. In this way a multi-dimensional reflection about the immediate events in question becomes possible and a richer giving and taking of meaning can occur. This process allows the narrative written by the researcher to be held alongside other narratives as potential contexts for ascribing meaning. These can be cultural myths (e.g. widely held and/or deeply embedded 'stories' about how men and women should behave), organisational and professional myths, family myths, individual life scripts, and so on - all can be seen as narratives which are inter-subjectively constructed.

In turn, the story once written informs the story lived. The role of action inquiry can then be to 'live' or test out the utility and efficacy of new stories in relation to others. Action Inquiry can also be seen in narrative terms, as the co-authoring of new stories with other participants. Each participant in this co-authoring will embroider their own personal meaning upon such stories in their own unique way. Action Inquiry can also structure experience in such a way as to give voice to previously silenced stories, giving them a 'space' in which they can be voiced and heard, allowing them to take their place alongside other stories. In this way more life-giving stories may be supported in challenging or replacing previously oppressive or life-sapping stories. Equally, the process of transformation may need to begin by hearing stories of oppression first.

My own experience of writing stories was that it connected me with a far wider range of experience than the immediate events which seeded the story. It facilitated my reflecting upon other stories, from the literature, from friends and colleagues, from my own store of stories about the past, and this process allowed the construction of richer stories about myself and the world. Narrative inquiry for me became the softer, richer fabric with which to embroider the web of action inquiry.

I see Narrative Inquiry as resolving some of the 'truth' concerns I had in relation to Naturalistic Inquiry's Authenticity criteria. This was the case in my particular use of Narrative Inquiry. But in weaving authenticity criteria into the research fabric, I see it as providing a stronger, more tensile thread, woven in sparsely with Narrative Inquiry and holding important questions about epistemology and about values in case they risk being obscured. The more an inquiry explicitly invites others to become co-researchers/co-subjects, and the more a research text seeks to represent the voice of others (even though it is the researcher's story about their story), the more visible will need to become the Authenticity thread.

Having reflected on the process of conducting the research, I will now turn to where this has taken me in practical term as a psychologist and what lies ahead in the future

Implications for practice as a psychologist.

Current.

It is at this point, in thinking about my current practice and in thinking about Torbert's notion of community of inquiry, that I become aware of a 'circle of friends' which has developed for me over the past six years. My relationships within this circle have been influenced by my research experiences, and reciprocally these relationships influenced my research. Yet they have not been mentioned in this account as the focus has been on a particular set of relationships within my work setting which claimed much of my attention on a day to day basis.

This circle is a loose network of like-minded mental health professionals who see the world in pluralistic ways, who are vitally interested in the interconnections between individual and social practices, who care about the quality of organisational life and change, and who hold similar values. They, like me, often feel lone voices in their own settings, but feel strengthened by the connections we have with each other. It is this which gives me hope.

Developments in the work setting.

At the time of writing, the department has many of the same members still working there, with a small number of changes and additions. The department now acts as 'host' for the Intensive Care Unit (ICU) which took over part of our building for that purpose. The ICU is a nurse-led service to the whole trust, with its own nursing team. It is supported by myself, William, the occupational therapist and the physiotherapist. I consult to the nursing team within the ICU and increasingly across the Trust in helping referring teams to manage the 'patient journey' in and out of the ICU. There are many problems to be resolved and I am now working with many of the individuals who attended my first meeting on Cooperative Inquiry. In the process of developing the ICU before it opened we used features of both Cooperative and Action Inquiry strategies in working together. These are stories which are untold in this research account.

The Core Group is now in regular dialogue with the Trust executive group and interested clinicians from other departments about forming a Trust-wide network of tertiary specialist services which collaborate with each other in working with clients who have special needs. The majority of these needs will be met by psychological treatments and interventions. We are at the early stages of this dialogue but already there are the signs of new patterns of relationship developing in which there is increasing inquiry and willingness to move toward collaboration. Needless to say, the old patterns which I have observed and commented on throughout are still present and 'have their way' periodically.

As a department the 'management of complex cases' forms a significant part of our tertiary specialist addiction services to our local district and the surrounding region. The second psychologist and the nurse/counsellor whom I eventually appointed to support my work are

taking on the key worker role for 'complex cases' with increasing confidence. Our conversations together have informed my research journey and have in turn been informed by my research experiences. William now also 'key works' complex cases. As a department we have adopted the key worker protocol developed by the day care team and it is continually reviewed and refined in the light of experience. As a result of our dialogue with other departments about a combined tertiary service we have been inviting interested clinicians to refer their clients to us who have complex needs and where drugs and/or alcohol complicate their treatment and care. We have been inviting them to remain key worker and have coached and supported them in trying it 'our way'. The feedback has been very encouraging and both clinicians and clients enjoy the degree of participation and the collaborative involvement.

I measure the success of the key worker role to the extent that individuals who occupy it are able to work between 'upstairs' and 'downstairs' patterns of interaction. There are increasing numbers who can do so. However, I find myself still 'riding' this boundary, coming in and out as needed to interrupt old patterns of rigidity and to support new patterns of flexibility. But whether I am less available now to do this or whether the frames implicit in the key worker role have become more established, I am less active in doing this and find myself less often 'invited' in to this position.

Occasionally I see and hear things which make me wonder if anything has changed. Occasionally I see and hear things which pleasantly surprise me. I called into the nurses office on the ward several weeks ago to hear William coaching a junior nurse in how to handle a difficult relationship with a patient for whom he was the key worker. He looked up as I entered. "There is a name for this series of steps, David can you remind me?" I asked if he meant framing, advocating, illustrating and inquiring. He proceeded to explain how she might implement such a strategy, modelling as he went.

Rosemary was finally discharged from our service after a two year period of working with us. She is working, divorced from her husband, and living apart from her parents. She went on from us to spend several months in a therapeutic community to work on her interpersonal relationships and while she was there I worked with her parents on issues from their own lives. I hear from both Rosemary and her parents from time to time. Rosemary is not drinking and has more control over her eating. She and her parents still have episodes of conflict, and Rosemary is still making "disastrous" choices about her relationships with men. However, she and her family manage their lives now without professional help and without recourse to extremes of risk-taking or risk-making behaviour.

The department continues to face both challenges and opportunities and its continued survival in its current form is not guaranteed. However, I see the boundaries between the department and its wider environment as less closed and rigid, more open and flexible, and therefore more adaptive to change. It is this which keeps me hopeful.

Personal/ Professional Development.

I started the research with questions about multi-disciplinary teams and these changed as the research progressed. The issues of power, gender, difference of professional and personal perspectives, and constructs about health, illness and social control are deeply structured. Each 'team' must find its own way of working 'around' these issues. I see more clearly than before that the training, professional world views and body of practice associated with the various disciplines does not equip its members to work collaboratively together in the best interests of clients, or of the teams and organisations of which they are a part. My experience is that it is only when individuals develop, both separately and together, the ability to notice and inquire into their own and others' assumptions, beliefs and practices can effective collaboration work. This has little to do with their expert knowledge which arises from their particular discipline. It is more to do with another 'discipline' altogether which is that of interpersonal competence and the development of a reflexive self-and-other awareness.

With regard to my own development over the course of the research I see two processes at play. The first was a process of 'de-construction', in terms of becoming aware of how the two themes of gender and power wove through my experience, or were 'meta-narratives' unawarely structuring my being and doing - these 'stories' living me and me living them. The second process was one of 're-construction', deriving a new set of constructs which led to a greater degree of congruence across the different domains of my experience. This 're-construction' is a continually emergent process, but the immediate effects for me were to place me more fully at the centre of my own sense-making and theorising about the world. The boundary rider metaphor encapsulates this for me. The 'key' learning theme for me throughout this research has been taking risks and listening to myself with a greater degree of trust than before. I have learned to 'listen' more carefully to my own experience and act on it.

So, where has this left me in relation to clinical psychology. I am still faced with contradictions. On the one hand the research has taken me even further beyond my immediate discipline into other areas of theory and practice. I have glimpsed what other writers are doing in their own fields and see that the boundaries are becoming increasingly open and there is much lending and borrowing of ideas. There are wonderful dialogues being held and to be held within the emerging new paradigm and clinical psychology is largely absent from these at present.

On the other hand I feel more connected with clinical psychology than before my research. In learning to listen more carefully to myself and my own experience, I have learned to listen more carefully and to inquire more thoroughly of other clinical psychologists. I have discovered a 'secret world' of experience with which I can resonate. Many clinical psychologists are privately asking themselves similar questions and having similar internal dialogues. They are living similar stories to the ones I was living as I came into the research. They have been silenced until recent times by the dominant 'story' in clinical psychology of the 'scientist practitioner' which honours objectivity at the expense of subjectivity.

This story is becoming more openly questioned and voice is given to other stories. This can be seen in the monthly clinical psychologists journal 'Forum' as practitioners write increasingly about exploring systemic therapies, experiment with qualitative research approaches, and occasionally reflect on some of the assumptions underlying their practice. This 'voice' is small but nonetheless present. Within my own network I have experienced the 'voicing' of alternative stories in exciting ways and it is with several brief stories about this that I wish to finish.

In giving a workshop to supervisors in which we explored the concept of reflexivity, I used an experiential exercise in which participants were asked to reconstruct an incident in clinical practice where they had an unexpected failure or success. The outcome of the exercise was for the participants to be able to share with each other all the different theories, models, and constructs which they had used to make sense of the incidents. We filled six large sheets of paper with the findings. The variety was both bewildering and exciting. Some participants had no formal names for the theories which informed their practice, and in describing them to the group gave them names, such as "my" theory, or the "muddle" theory. This gave rise to very interesting dialogue, as some of the participants were teachers and trainers of clinical psychology. There was much confusion and pockets of revelation as we tried to explain these in relation to the scientist practitioner model.

Following this workshop, some months later, I was approached by the director of the local clinical psychology training course (to which I contribute) to contribute to the learning of the course tutors. They for some time had recognised the need to understand more about qualitative research and were setting up a series of seminars for themselves and would like me to run one on the theoretical and philosophical underpinnings. I was both delighted and flattered to accept.

Over the last year, as I have voiced more strongly my interests within the teaching and supervision I provide to the training course as a practitioner, I have had increasing interest shown in return by the trainees in doing qualitative research for their projects. I realise I am riding a boundary between the thirst of the trainees to find a form of research which fits better their experience, and the tensions of the trainers who both wish to meet that need but also feel responsible to the wider domain of clinical psychology as it is still practised, with its public adherence to the scientist practitioner model. There are interesting times ahead.

Lastly, I would like to recount a brief encounter with a clinical psychologist colleague which illustrated for me, on reflection, much of where the research had brought me to in my continuing journey. This colleague found out about my interest in qualitative research through a trainee she was supervising who had consulted me about her research project. The clinical psychologist , together with two colleagues, had carried out a piece of research into the setting in which they worked, They had written it up for publication but were very unhappy with the draft which moved uneasily between the qualitative and the quantitative aspects of the research, doing justice to neither. I was asked to read the draft and to help with their

difficulties. On receiving the draft, and feeling very pressured for time (writing this thesis) I noted a tension between two opposing tendencies. One tendency was to put the draft aside until I could give it the time I felt it deserved, so that I could think long and hard and 'get it right' for them. The other tendency was to do it 'now ', recognising that I would never have 'enough time' and trust that I would have at least something to offer, and that immediate feedback would probably be more helpful than delayed feedback. I read it over lunch, scribbled notes on one side of A4 paper, called my colleague and made a time to meet over lunch the following week.

We went through the draft together in half an hour, and I gave feedback about the implicit and explicit themes I saw in the report which could be elaborated on, I inquired into and commented on the implicit models and assumptions carried by the researchers but not made explicit in the draft, and I referred them to literature I knew of which related to their interests. This feedback confirmed what my colleague had been feeling about the research and named and elaborated what her confusion had been about. We then went on to discuss qualitative research and clinical psychology. She had originally trained as a sociologist but went into clinical psychology because it offered more certain and secure employment. She felt she had 'sealed off ' this whole body of knowledge and the perspectives it offered to her work. Our conversation had re-affirmed the importance of taking a wider perspective and of using all the knowledge available to her. She talked about how her sociological knowledge could help with making sense of her research. We then shared several stories of our own experiences of seeking a form of research and a way of 'knowing about things' which fitted with the complexity of our professional and personal experiences. We parted agreeing to meet again and invite others to join us in exploring how we could use qualitative research in our work.

What the encounter meant to me was that I was prepared to trust my instincts and intuition and move in a timely way to take 'advantage of the moment'. This for me was a risk because in the past I have tended to be much more circumspect about giving advice, feeling that I would have had to put in considerable effort to 'get it right' and give a thorough, 'expert' and considered opinion. In this situation I trusted much more that I had 'something' to offer without extensive prior preparation, that it would be the dialogue which was important, that my colleague would take her own meaning from what I had to offer and map it onto her own experience, and that it was the connecting with each other and the participation in sharing and creating 'new stories' which was the essence. It was the quality of the interaction and the co-creating of new or elaborated understanding which was important and I am much more trusting of this.

So, I am both more 'of ' clinical psychology at this stage of my journey, and more 'outside'. The two core themes of my 're-constructed' sense of myself as a clinical psychologist are those of *participation* and *connection*, both internally and externally, and across the past and the future.

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